Baptist Hospital of SETX-BEAUMONT Financial Information Form

______________________________ Print Patient Name

______________________________ Account No. or Social Security No.

______________________________ Print Guarantor/Parent Name(if different from above)

______________________________ Social Security No.

Instructions: All questions must be answered. If a question does not pertain, write N/A on the line. Attach a photocopy of **one of the following** proofs of income to the completed form:

1. Letter of support from friend/family.
2. Last years tax return statement
3. Social Security check or award letter
4. Last 2 paycheck stubs
5. Unemployment or Food Stamp award letter
6. Letter from employer- (to include employee name, hourly wage, number of hours worked.)

PLEASE INCLUDE A COPY OF YOUR RECENT BANK STATEMENT FOR ANY BANK ACCOUNTS YOU MAY HAVE

Citizenship (check one): _____US Citizen _____Non-US Citizen

Marital Status (check one): _____Married _____Single _____Divorced _____Separated ______Widowed

Name of Dependants **(legal deductions on your tax return)** Number in the Household______________

Name:____Relationship:_________________Date of Birth____________

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Name:____Relationship:_________________Date of Birth____________

Name:____Relationship:_________________Date of Birth____________

Housing (check one): _____Own _____Rent _____Paid House/Rent Payment $________________/month

Utilities: Electricity $__________/month Gas $__________ /month Water $__________/month

Automobiles: Own (How many?)______ Lease (How many?)______ Car Payment (s): $__________/month

Bank Accounts/Other Assets: **(must answer all three questions)** Attach a photocopy of bank statement.

Checking Account? (Circle One) Yes No $___________ Savings Account? (Circle One) Yes No $___________

Additional Assets? (Circle One) Yes No Describe:____

Include vehicles year/make/model

Employment-PATIENT/GUARANTOR Name of Employer:____

Employment-SPOUSE Name of Employer:____

Patient/Guarantor
_____ Employed Full Time
_____ Employed Part Time
_____ Not Employed

Spouse
_____ Employed Full Time
_____ Employed Part Time
_____ Not Employed

Other Support

Social Security $_________/month
Trust Fund $_________/month
Unemployment $_________/month
Child Support $_________/month
Survivors Benefit $_________/month
Workman's Comp $_________/month

Total Family Income $___________________ **per month (Award requires proof of income with application)**

I hereby declare that the above information is true and correct. If the information supplied is inaccurate or incomplete or the patient's family income exceeds the charity guidelines, I understand that I will be responsible for payment of the entire balance of the bill. I understand this determination is conditional and does not apply to third party claims such as lawsuits, settlements, hospital liens, or any other third party payment or liability. Baptist Hospitals of Southeast Texas retains its rights to recover the full balance of my bill from any third party resource to the fullest extent allowed by law. If my (our) case is selected for Indigent Care classification, I (we) give my (our) consent to the Baptist Hospitals of Southeast Texas to obtain information from any source to verify the statements I (we) have made.

______________________________ Parent/Guarantor Signature

______________________________ Date