BEAUMONT

Baptist Hospitals of SETX

Financial Information Form

_____ _____

Print Patient Name Account No. or 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. Last years tax return statement
2. Last 2 paycheck stubs
3. Letter from employer – (to include employee name, hourly wage, number of hours worked)
4. Award Letter
5. Unemployment or Food Stamp award letter

Citizenship (check one): ____US Citizen____ Non–US Citizen

Marital Status (check one):____ Married ____ Single ____ Divorced

Names of Dependents **(legal deductions on your tax return**) Number in household _____

Name:_____Relationship_____Date of Birth_____
Name:_____Relationship:_____Date of Birth_____
Name:_____Relationship:_____Date of Birth_____
Name:_____Relationship:_____Date of Birth_____
Name:_____Relationship:_____Date of Birth_____
Name:_____Relationship:_____Date of Birth_____

Housing (check one): ____Own ____ Rent ____ Paid House 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? Yes No $_____ Savings Account? Yes No $_____

Additional Assets? (Circle one) Yes No Describe:_____

Employment –PATIENT-_____Name of Employer:_____

Employment – SPOUSE/GUARNTOR – Name of Employer:_____

Patient	____	Employed Full Time	Spouse/Guarantor	____	Employed Full Time
____		Employed Part Time		____	Employed Part Time
____		Not Employed		____	Not Employed

Other Support Alimony $_____ per month Child Support $_____ per month
Trust Fund $_____ per month Survivors Benefit $_____ per month
Unemployment $_____ per month Workman's Comp $_____ per 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 doe 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.

_____ _____

Patient/Guarantor Signature Date

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Financial Information Form

_____ _____

Print Patient Name | Account No. or Social Security No.

(Insert Name)
(Insert Address)
(Insert City/state)

Dear (insert Guarantor name)

We would like to take this opportunity to thank you for choosing Baptist Hospitals of SETX as your healthcare provider.

In order to help facilitate the settlement of your accounts we are sending you a financial information form. Please complete all areas, sign it at the bottom and return to us with **proof of income** and **bank statements** for your checking and savings accounts. Proof of income can be last year's tax return, last two pay stubs, unemployment benefit confirmation slip, a letter from your employer stating name, occupation, hourly wage and number of hours worked or proof of subsidized income such as an SSI relief or social security letter.

Upon receipt of the information, we will have it reviewed to see if you are eligible for any county and/or hospital assistance on the account in question. This assistance is available for those that meet certain Federal income guidelines. After the review, you will be notified of the determination. If approved, you can be eligible for part if not all of your hospital bill to be covered by this program.

If you have any questions please call customer service **409-212-6141** or simply return the financial information form and proof of income to the following address:

Baptist Hospitals of SETX
Attn: **Business Office**
PO Box 1591
Beaumont, Texas 77704

Sincerely,

Insert – your name here and sign