BEACON MEDICAL GROUP

ELKHART GENERAL HOSPITAL

MEMORIAL HOSPITAL

CONFIDENTIAL FINANCIAL EVALUATION

Date to Guarantor: _____ **Return by:** _____ or call (574) _____

Patient Name: _____ Date of Birth: _____

Guarantor Name: _____ Account # (s): _____

Address: _____

Daytime phone/message: _____ Cell phone: _____

E-mail address:

HOUSEHOLD MEMBERS

Name:	Age:	Relation:	Name:	Age:	Relation:

HOUSEHOLD MONTHLY INCOME

Name:	Employer:	Hire Date:	Term Date:	Gross Monthly Income

OTHER MONTHLY INCOME

Soc. Sec. $ _____ Disability $ _____ Unemployment $ _____ Pension: $ _____

TANF $ Child Support/Alimony $ Rental Prop. $ Other: $

BANK ACCOUNTS

Bank Name:	Type (circle one)	Account #:	Balance:
	Savings/Checking		
	Savings/Checking		

OTHER ASSETS

(STOCKS, BONDS, TRUSTS, 401K, LIFE INSURANCE CASH VALUE, IRA, CD, INVESTMENTS, ETC)

Type: Value:

MONTHLY MEDICAL EXPENSES

Prescriptions: Other:

INCLUDE VERIFICATION OF INCOME, 3 MOST RECENT PAY STUBS AND BANK STATEMENTS, AND TAX RETURN WITH ALL SCHEDULES

If you do not have any income, please provide letter of support and explanation of how your living expenses are paid.

I certify that all information is true and complete to the best of my knowledge. I understand that information provided will be verified and treated as personal and confidential. I further authorize Beacon Health System providers to obtain a credit report, banking information and employment information. I understand that I must provide verification of Income, dependents, bank statements, pay vouchers and tax statements. I also understand that I will be liable for full payment of any services rendered at any Beacon Health System provider if the above information is given under false pretenses.

Guarantor Signature: _____ DATE _____

Spouse signature: _____ DATE _____