PHYSICIANS CARE SURGICAL HOSPITAL
FINANCIAL ASSISTANCE FORM

INSTRUCTIONS FOR COMPLETING THIS FORM

In order for a patient to be eligible for special financial consideration, this form should be completed and the requested documentation attached, and the form returned to the **Physicians Care Surgical Hospital.** The information will be verified and proper determination will be made in a timely manner. Please provide the following documentation to the facility:

- This form, completed and signed
- Copies of signed Federal Income Tax Return for previous year
- Copies of payroll check stubs for the previous 2 months
- Copies of recent utility bills, rent/mortgage receipt, medical bills, auto loan receipts, bank statements, alimony/child support receipts, government assistance receipts, other income/investment statements (e.g. 401K statement)

RESPONSIBLE PARTY INFORMATION

Responsible Party _____ Marital Status _____

Address _____ State _____ Zip _____

SSN _____ Birth Date _____ Phone _____

Employer _____ Position _____ Phone _____ Hire Date _____

Address _____ City _____ State _____ Zip _____

Spouse _____ Birth Date _____ SSN _____

Spouse's Employer _____ Position _____ Phone _____ Hire Date _____

Number of children in the house _____ Ages _____

MONTHLY INCOME INFORMATION

Please provide documentation of income sources -- W-2 forms, income tax statements, check stubs, or check statements. A financial statement may be required if you are self-employed.

	Responsible Party	**Spouse**
Wages before deductions		
Alimony/Child support		
Disability/worker's comp		
Pension		
Social Security Income		
Dividends/Interest Income		
Rental Income		
Estate Trust Income		
Welfare/Public assistance		
Food Stamps		
Other (please list)		
Less State/Federal Taxes		
Less any other deductions		
Monthly Income Total	$	$

For help in completing this application, please contact the Billing Office by phone at 610-495-3330. In person assistance is also available by asking for a Business Office Associate at the Registration Desk of Physicians Care Surgical Hospital at 454 Enterprise Drive, Royersford, PA 19468.

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FINANCIAL INFORMATION

ASSETS	VALUE		VALUE
Cash/Checking		Investments	
Savings		Life Insurance	
Stocks and Bonds		Other	

ALL REAL PROPERTY AND VEHICLES

				VALUE	BALANCE	MONTHLY PAYMENT
Residence rent / own (circle one)						
Other property						
Vehicle #1	Make	Model	Year			
Vehicle #2	Make	Model	Year			
Vehicle #3	Make	Model	Year			

MEDICAL EXPENSES

Medical Provider's Name	BALANCE	INS WILL PAY	MONTHLY PAYMENT

LIST ALL OTHER CREDITORS

(Charge cards, mail order, etc. - - attach separate sheet if necessary)

CREDITOR'S NAME	TYPE LOAN	BALANCE	MONTHLY PAYMENT

Appliance or furniture rental: _____

Have you ever filed bankruptcy? Yes No Give date _____

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OTHER MONTHLY EXPENSES

EXPENSE	MONTHLY PAYMENT	EXPENSE	MONTHLY PAYMENT
Food	_____	Auto Insurance	_____
Phone	_____	Cable TV	_____
Electric/Gas/Water/Sewer	_____	Health Insurance	_____
Contributions	_____	Recreation	_____
Other (List)	_____	Other (List)	_____

FOR OFFICE USE ONLY...

MONTHLY FINANCIAL SUMMARY

Total Income: _____

Subtotals:

Real property
Vehicles $_____

Monthly Medical
Expenses $_____

Creditors
Credit $_____

Other Monthly
Expenses $_____

Total Expenses: _____

PATIENT CONDITIONS AND COMMENTS

Please answer the following questions – attach additional pages if necessary

Have you applied for Medicaid and been denied or found to be ineligible? Yes No (circle one)

Have you asked for assistance from your family? Yes No (circle one)

_____

Have you asked for assistance from your clergy or church? Yes No (circle one)

_____

How much are you able to pay each month? _____

COMMENTS: _____

_____

I hereby state that the information I have provided is true and complete. I authorize **Physicians Care Surgical Hospital** to verify this information, including requesting a credit bureau report. I understand that if any of this information is determined to be deceptive or false, I may be denied special financial consideration and I will be liable for payment of any and all charges incurred for the services rendered.

X _____ **Date:** _____

Responsible Party Signature

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