PATIENT FINANCIAL ASSESSMENT FORM

Date: _____ Account #: _____
Social Security #: _____
Patient last name: _____
First name: _____
Address: _____City: _____
State: _____. ZIP: _____
Phone #: _____
Alternate phone #: _____
Name of responsible party (if not patient, print name Guarantor):
_____
Patient's employer: _____
Employer phone #: _____
Employer address: _____City: _____
State:_____. ZIP: _____
Length of employment: _____
If unemployed, last date of employment: _____
Spouse last name: _____
First name: _____
Spouse employer: _____
Employer phone #: _____
Employer address: _____City: _____
State: _____. ZIP: _____

Length of employment: _____. If unemployed, last date of employment: _____
Total in household (include yourself):
Adults (18+) _____
Minors (under 18) _____

Guarantor (responsible party) employer: _____Phone #: _____
Employer address: _____City: _____State: ____ZIP: _____
Length of employment: _____
If unemployed, last date of employment: _____

Income (monthly)	Patient	Spouse	Responsible Party	Children Working
Gross Monthly Salary	$	$	$	$
Public Assistance Benefits	$	$	$	$
Unemployment Benefits	$	$	$	$
Social Security Benefits	$	$	$	$
Workers' Compensation	$	$	$	$
Child Support	$	$	$	$
Other: (Alimony, Pension, Life Insurance, Veterans Administration [VA] Benefits, Disability)	$	$	$	$

Totals: $_____ $_____ $_____ $_____
Total family income: $_____
Other
assistance: _____
___
Have you applied for Medicaid: Yes No (circle)
If "yes," provide current status or attach denial
letter: _____
Have you tried to obtain financial assistance from other organizations? Yes No (circle) List the organizations and current status:
_____
_____ _____
_____
List all outstanding medical bills:

1. _____
   _____
2. _____
   _____

3. _____
_____

4. _____
_____

5. _____
_____ Please provide any additional information/comments:

(Attach additional sheet if more space is required, or use the back of this form.)

_____
_____ _____
_____

Financial Documentation: (attach copies)

Previous year 1040 IRS: $_____ Year _____

W-2s: $_____ Year _____

If patient claims income is less than the previous calendar year tax form; attach most recent four pay stubs.

$ _____ Date _____

$ _____ Date _____

$ _____ Date _____

$ _____ Date _____

Other (unemployment, Social Security, disability and workers' compensation): (attach copies)

$ _____ $ _____

	Monthly Payment		Credit Limit	Balance	Monthly Payment
Mortgage/rent	$	VISA	$	$	$
		MC	$	$	$
		AMEX	$	$	$
		Discover	$	$	$
Gas & electric	$		Other Expenses (Provide Explanation)		
Telephone	$				$
Car insurance	$				$
Food	$				$
Total monthly expenses this column	$				$
Total monthly expenses other column	$				$
Monthly expense grand total	$			Total	$
Yearly Household Income					

Gross:	$
Net:	$

- *I declare that I have examined this application and to the best of my knowledge all information in it or otherwise provided to Western Carolina Digestive Consultants is true, correct, and complete. I understand that misrepresentation of this information may cancel any financial assistance I may be provided and that I will then be liable for all medical charges.*
- *By signing and submitting this request, I give Western Carolina Endoscopy Center, LLC and Western Carolina Digestive Consultants, P.A permission to determine my need for financial assistance, including review of my credit file. I also give permission to Western Carolina Endoscopy Center, LLC and Western Carolina Digestive Consultants, P.A. to release or disclose this information to Western Carolina Endoscopy Center, LLC and Western Carolina Digestive Consultants, P.A. for the purpose of evaluating my financial status in response for assistance with my medical charges.*
- *I understand that it is my responsibility to advise Western Carolina Endoscopy Center, LLC and Western Carolina Digestive Consultants, P.A. of any changes in status in regards to my income or assets while this application is in process.*

Signature of patient: _____

Date:_____

Signature of spouse or guarantor:

_____ Date:_____

Return this form and supporting documentation within 30 days to the Practice where you received services or mail to 26 WestCare Drive Suite 302 Sylva, NC 28779. If you have questions, you may call 828.586.9200.

For Office Use Only

Total wages for calendar year: $ _____

Total household: $ _____ Eligible discount:

% Federal Poverty Level / Discount

300%	30%
200%	50%
100%	75%
<100	100%

Discount Amount: $
Date completed: _____ By: _____
Notes: _____
_____
_____
_____ Check when completed:
__ Discount screen
__ Patient alert(s)
__ Added to practice management system
Name/Phone #: _____