Memorial Healthcare System

FINANCIAL EVALUATION FORM

Account Number:		MR Number:

Patient's Name:_____ Social Security Number: _____
Street Address:_____ Telephone #:_____
City:_____ST:_____ ZIP: _____

Please provide the following information completely and accurately. Information is subject to verification. ***In accordance with Florida Statute Section 817.50, providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second (2nd) degree.***

List All household member names	Date of Birth	Social Security Number	Relationship to patient	Employer

Monthly Income		**Monthly Expenses**	
Responsible Party's Gross Salary	$	Rent/Mortgage/Housing	$
Spouse's Gross Salary	$	Electricity	$
Investment Income	$	Water/Sewage	$
Child Support/Alimony	$	Telephone	$
Rental Property Income	$	Groceries	$
Annuities/Stocks/Dividends	$	Transportation (automobile+insurance)	$
Pension/Retirement/Unemployment	$	Medical Bills	$
Other:	$	Other:	$
Total Monthly Income	$	**Total Monthly Expenses**	$
Assets		**Liabilities**	
Value of Residence(s)	$	Residence Loan Balance/Mortgage	$
Checking Account	$	Balance Owed on Credit Cards	$
Savings/Money Market/CD's	$	Auto Loan	$
Value-Auto/Boat	$	Medical Bills (total outstanding)	$
Other:	$	Other:	$
Total Value of Assets	$	**Total Liabilities**	$

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at time of registration. I understand that providing false information will result in denial of the application for any type of financial assistance through the South Broward Hospital District d/b/a/ Memorial Healthcare System. If I am entitled to any action against or settlement from third party payors, I will take any action necessary or requested by Memorial Healthcare System to obtain such assistance and will assign to Memorial Healthcare System, and upon receipt will pay to Memorial Healthcare System, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by Memorial Healthcare System will result in the denial of this application. I also authorize Memorial Healthcare System to check my credit history through the credit bureau, if deemed appropriate.

_____ _____
Signature of Patient (Responsible Party) Date

_____ _____
Witness Extension

Billing Number: