

		ACCOUNT #:	T	
		PATIENT NAI	ME:	
FINAN	CIAL S	STATEN	IENT	
LAST NAME (RESPONSIBLE PARTY)	FIRST	MIDDLE	SOC SEC#	BIRTHDATE
MAILING ADDRESS		HOWI	ONG	PHONE
CITY	S	TATE		ZIP
PATIENT (IF DIFFERENT FROM ABOVE0				
,				
RESPONSIBLE PARTY EMPLOYER (NAMI	E & FULL AD	DRESS)		
		,		
	PHONE		M	ONTHLY GROSS PAY
			\$	
OTHER EMPLOYER (NAME & ADDRESS)		,		
	PHONE		Mo	ONTHLY GROSS PAY
F UNEMPLOYED NAME LAST EMPLOYER	D (NIAME O. A	DDDDGG	\$	
TO THE TOTAL THREE PAST EMPLOYER	K (NAME & A	DDRESS)		
			LAST EMPL	OYMENT DATE
			ENGT ENT	OTMENT DATE
AMILY MEMBERS BIRTHDATE	RELATION	SHIP EMPI	OYER	EMPLOYER PHONE
			JO I EIK	LIVII LOTER PHONE
				

		OTHER MONTHLY INCOME	\$	(SPECIFY SOURCE)
RENT	OWN		-1-4	

OWED TO OTHERS To V	Whom	PRESENT	MONTHLY
Ow	ed	BALANCE	PAYMENT
RENT/			TATMENT
MORTGAGE			
UTILITIES			
FOOD			
AUTO LOAN			
AUTO			
INSURANCE			
CREDIT CARDS			
OTHER OBLIGATIONS (Example			
Insurance Payments, Child Support,	Alimony		
110000000000000000000000000000000000000			
*ADDITIONAL INFORMATIC SEE BACK)N		

ASSETS	BANK NAME & ACCOUNT NUMBER	BALANCE OF ACCOUNT \$
CHECKING		•
SAVINGS OR		
CERTIFICATE		
401K PLAN		
STOCKS &		
BONDS		
IRA		
AUTO		
(YEAR & MAKE)		
AUTO		
(YEAR & MAKE)		
RESIDENCE - MARKET	VALUE	
INSURANCE		
CASH VALUE	_	
OTHER ASSETS		
DESCRIBE		
TOTAL ASSETS		

DATE COMPLETED_ *MEDICAL EXPENSES – PLEASE INCLUDE BILI	S OR STATEMENTS OF BALANCE*
PATIENT LIABILITY EXPENSES: (Enter only those expenses for which the patient or respons A. PHYSICIAN(S) BILLS:	
B. PRESCRIPTION DRUG MEDICATIONS: (Purchased regularly monthly/weekly, etc.)	
C. EYE CARE:	
D. DENTAL BILLS:	
E. HOSPITAL/HEALTHCARE FACILITY BILLS:	
F. OTHER MEDICAL BILLS/EXPENSES	
G. TOTAL OTHER EXPENSES (Add Lines A through F):	
COMMENTS:	
I CERTIFY THAT ALL STATEMENTS MADE IN THIS FINANC COMPLETE. YOU ARE HEREBY AUTHORIZED TO CHECK N EVALUATE THIS FINANCIAL STATEMENT.	CIAL STATEMENT ARE TRUE AND TY CREDIT HISTORY IN ORDER TO
SIGNATURE:	DATE
	DATE:

PLEASE RETURN IN ENCLOSED ENVELOPE OR RETURN TO:
PATIENT FINANCIAL SERVICES ◆ 822 7TH STREET ◆ SUITE 10 ◆ GREELEY ◆ CO ◆ 80631

FOR ASSISTANCE, PLEASE CALL PATIENT FINANCIAL SERVICES (970) 506-6500 OR 1-800-239-2835



Patient / Responsible Party

APPROVED BY:____

APPROVED BY:_____

FINANCIAL ASSISTANCE WORKSHEET

DATE:____

DATE:____

FACILITY	NAME		
EST. AMOUNT \$ ACCO	UNT NUMBER		
A. ASSETS AND RESOURCES: 1. Cash and Securities: 2. Insurance Cash Values: 3. Total Liquid Assets: (Line 1 plus Line 2) 4. Equity in Residence 5. Vehicles (Net Worth) 6. All Other Assets	B. INCOME: 1. Employment Earnings: 2. Education Earnings: 3. Self Employment: 4. Other Income: 5. Total Monthly Gross Income (Add Line 1 through Line 4)		
7. Total Property (Add Line 4 through Line 6):	6. Total Annual Gross Income (Line 5 x 12): MEDICAL EXPENSES:		
STATUS YES NO Applicant within Limits	(Enter only those expenses that are patient responsibility) 7. Physician(s) Bills:		
Liquid Assets \$5,000 or Less			
•	8. Prescription Drugs & Medications:		
Equity in Res \$80,000 or Less	9. Eye Care:		
Vehicles/All Other Assets \$10,000 or Less	10. Dental Bills:		
Colorado Resident	— 11. Hospital/Healthcare Facility Bills:		
Number of Persons in Household	12. Other Medical Bills/ Expenses:		
OTHER CONSIDERATIONS:	13. Total Medical Expenses: 14. Total Net Income		
	(Line 6 minus Line 13):		
MY SIGNATURE SIGNIFIES THAT THE INFORMATION	ABOVE IS TRUE AND CORRECT.		
SIGNED BY:Patient / Responsible Party	DATE:		
REVIEWED BY:	DATE:		