PALO VERDE HOSPITAL

250 N. First Street
Blythe, CA 92225

DATE RECEIVED___________RECEIVED BY____________

INSTRUCTIONS FOR COMPLETING THIS FORM

In order for a patient to be considered for special financial consideration, this form should be completed and the requested documentation attached, and the form returned to _______________ at the hospital. The information will be verified and a proper determination will be made in a timely manner. Please provide the following documentation to the facility:

1. ___*This form, completed in its entirety.*
2. ___*Complete copies of signed Federal Tax Returns with all schedules (For the most recent 2 years).*
3. ___*Copies of payroll check stubs for the previous (3) months.*
4. ___*Any/all other documentation that may be required by the facility.*

RESPONSIBLE PARTY INFORMATION

Responsible Party Name: ____ Marital Status: ______________

Address: ______________________________ City: _______________ St: _______ Zip: _______________

Social Security #: ______________________ Birth Date: ______________ Phone #: _________________

Employer: ____________________________ Phone #: _______________ Date of Hire: _______________

Address: ______________________________ City: _______________ St: _______ Zip: _______________

Spouse's Name: _______________________ Birth Date: ______________ SSN #: ___________________

Spouse's Employer: _________________________ Phone #: _________ Date of Hire: _____________

Number of Children in the Home: _______________ Their Ages: ___________________________________

FOR OFFICE USE ONLY
List Account Information for Members in Household:
(For Additional Members - Attach a Separate Sheet if Necessary)

Patient Name:	Account #:	Balance:	Age:	Relationship:

MONTHLY INCOME INFORMATION

Income Sources **(W-2 form, income tax statement, check stubs, or check statements are required for verification. A financial statement may be required if you are self-employed.)**

	Responsible Party	Spouse
	Must have 3 current months of statements for both	
Wages (Before Deductions)	$ ______	$ ______
Alimony / Child Support	$ ______	$ ______
Disability / Worker's Compensation	$ ______	$ ______
Pension	$ ______	$ ______
Social Security Income	$ ______	$ ______
Dividends / Interest / Income	$ ______	$ ______
Rental Income	$ ______	$ ______
Estate / Trust Income	$ ______	$ ______
Welfare / Public Assistance	$ ______	$ ______
Food Stamps	$ ______	$ ______
Other (Please List)	$ ______	$ ______
Less FICA/State/Federal Taxes	$ ______	$ ______
Less Any Other Deductions	$ ______	$ ______
MONTHLY INCOME TOTALS:	$ ______	$ ______

Have you ever filed Bankruptcy? Yes ______ No ______ Year: 19______

ASSETS

Must have 3 current months of statements

	Value		Value
Cash / Checking	$ ______	Investments	$ ______
Savings	$ ______	Life Insurance	$ ______
Stocks / Bonds	$ ______	Other	$ ______

MONTHLY PAYMENTS

ALL REAL PROPERTY/VEHICLES

Must have 3 current months of statements

	Balance Due	Monthly Payment
Residence (Own ___ Rent ___)	______	______
Other Real Property (List) ______	______	______
Vehicle #1: Make ______ Model: ______ Year: ______	______	______
Vehicle #2: Make ______ Model: ______ Year: ______	______	______
Recreation Vehicle: ______ Model: ______ Year: ______	______	______
Other Vehicle: ______ Model: ______ Year: ______	______	______

MONTHLY PAYMENTS CONTINUED—*Must have 3 current months of statements*

Medical Expenses

Hospital / Physician Name / Pharmacy	Balance Due	Amount Insurance Will Pay	Monthly Payments

List All Other Creditors –***Must have 3 current months of statements***

(Charge Cards, Mail Order, Gas Cards, etc. - Attach a separate sheet if necessary)

Name of Creditor	Type of Loan	Balance Due	Monthly Payments
Appliance Furniture Rental:			
Other:			

Other Monthly Expenses — ***3 current months of statements***

	Monthly Payment
Food	

Must have 3 currently months of statement for all below

Auto Insurance 6 months $______	
Gasoline	
Health Insurance (If not deducted from payroll)	
Prescriptions	
Utilities:	
Heating Fuel	
Phone	
Water / Garbage	
Electrical	
Cable TV	
Contributions	
Other (List): ______________	

PAYMENT SUBTOTALS: $________________

Monthly Financial Summary

TOTAL INCOME: $ ____________________

SUBTOTALS:

Real Property / Vehicles $ ____________________

Monthly Medical Expenses $ ____________________

Revolving Credit $ ____________________

Other Monthly Expenses $ ____________________

TOTAL EXPENSES $ ____________________

PATIENT CONDITIONS AND COMMENTS
Please Explain (Attach a separate sheet if necessary)

- Have you applied for Medicaid and been denied or found to be ineligible? If so, attach denial.
  Yes _______ No _______

IF NO IS CHECKED, THE APPLICATION IS DENIED

- Have you asked for assistance from your family? Yes _______ No _______

IF YES, WHAT WAS THE OUTCOME____

IF NO IS CHECKED APPLICATION IS DENIED

- Have you asked for assistance from your clergy / church? Yes _______ No _______

IF YES, WHAT WAS THE OUTCOME____

IF NO IS CHECKED, THE APPLICATION IS INCOMPLETE. MUST STATE WHY YOU DID NOT ASK FOR ASSISTANCE

- 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 Ashley Valley Medical Center 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 any and all charges incurred for services rendered.

[ ] _______________________________________ _______________
Responsible Party's Signature Date

FOR OFFICE USE ONLY

APPROVAL SIGNATURES AND COMMENTS

_______________________________________ _______________
Financial Counselor Date

_______________________________________ _______________
Patient Financial Services Director / Manager Date

FACILITY COMMENTS: ____

____

____

Total Charges: $_____________ Insurance Payments: _____________ Patient Payments: _____________

Financial Consideration: _____________________ Total Balance Due: _____________