EXHIBIT A

Patient Name_____	**Facility:_____ DOS:_____**
Patient Number_____	**Confidential Financial Statement (Application)**

RESPONSIBLE PARTY

Name	Marital Status	Social Security Number
Street Address, City, State, Zip	How long at this address	Home Phone
Employers Name and Address (If Unemployed –How Long)		Business Phone
Position / Title	Monthly income – Gross	Monthly income - Net	Length of current employment

SPOUSE

Name			Social Security Number
Employer Name and Address			Business Phone
Position / Title	Monthly income – Gross	Monthly income – Net	Length of current employment

DEPENDENTS

Name & Year of Birth of all dependents in household	Total Number of dependents in household____	Do Any Other Persons Contribute? If Yes, Amount: Yes/No _____ Amount _____

INCOME PER MONTH & ASSETS

Dividends, Interest	$	Child Support / Alimony	$
Public Assistance / Food Stamps	$	Rental Income	$
Social Security	$	Grants	$
Unemployment Compensation	$	IRA	$
Workers' Compensation	$	Other	$
Savings	$		

EXPENSES PER MONTH

Mortgage / Rent Payment:	$	Balance: $	Medical / Dental		$
Own Home? (Yes/No)			Doctor – Name		$
Food	$		Doctor – Name		$
Utilities:	$		Doctor – Name		$
Electric	$		Credit Cards:		$
Gas	$		Visa	Limit	$
Water / Sewer	$		Mastercard	Limit	$
Trash	$		Discover	Limit	$
Phone	$		Other	Limit	$
Cable	$		Installment Loans		$
Auto Payments	$		Child Support		$
Auto Expenses	$		Miscellaneous Expenses		$
Insurance:					
Auto Premium	$				
Life Insurance	$				
Health Insurance	$				

OFFICE USE ONLY
Gross income_____
Net income_____
Total Expenses_____
Total Net income(loss)_____

To my knowledge the information provided above is true.

_____ _____
PATIENT/GUARANTOR SIGNATURE DATE