

FINANCIAL EVALUATION FORM

Schedule of Current Income and Expenditures

PATIENT NAME _____ **SPOUSE** _____
ADDRESS _____ **PHONE** _____

SOCIAL SECURITY NUMBER _____ (Patient) _____ (Spouse)

A. FAMILY STATUS

1. List all dependents that you support

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. EMPLOYMENT AND OCCUPATION

- Employer:** _____ **Position** _____
Contact Person & Telephone _____
If self employed, give name of business _____
- Spouse Employer:** _____ **Position** _____
Contact Person & Telephone _____
If self employed, give name of business _____

C. CURRENT MONTHLY INCOME

	Patient	Spouse
1. Gross pay (before deductions) from employment	\$ _____	\$ _____
2. Income from operating business (If self employed)	\$ _____	\$ _____
3. Other income:		
Interest and dividends	\$ _____	\$ _____
From real estate or personal property	\$ _____	\$ _____
Social Security	\$ _____	\$ _____
Other – specify	\$ _____	\$ _____
4. Alimony, support payments	\$ _____	\$ _____
5. Total Current Monthly Income (1 to 4)	\$ _____	\$ _____

D. UNUSUAL EXPENSES OR INCOME

Please provide information on any unusual expenses or income such as previous Medical bills, a recent bankruptcy, court judgments or one-time earnings.

E. ASSETS AND DEBTS

Please provide your best estimate of the value of any homes, cars, or similar Assets. Also, indicate how much debt you currently have.

- 1. Assets
 - a. Home and Property \$ _____
 - b. Retirement Plan \$ _____
 - c. Investments/Other (specify) \$ _____
- 2. Debts
 - a. Amount owed on mortgages \$ _____
 - b. Amount owed on credit cards \$ _____
 - c. Other (specify) \$ _____

My or our signature(s) on this form allows College Hospital Costa Mesa to verify the information on the form, including permission to contact employers and to check my or our credit history.

(Date)

(Signature of Patient or Guarantor)

(Date)

(Signature of Spouse)