

Financial Information Form Assistance Application

1. Patient Name _____ 2 Account Number _____
 Guarantor Address _____
 Phone # _____

3. Household Information: Number of People living in same household _____

4. List Household Members	DOB	SSN	Monthly Income
Patient _____	_____	_____	\$ _____
Guarantor _____	_____	_____	\$ _____
Spouse _____	_____	_____	\$ _____
Other _____	_____	_____	\$ _____
Other _____	_____	_____	\$ _____
Other _____	_____	_____	\$ _____
Other _____	_____	_____	\$ _____
Total Household Income			\$ _____

5. Assets
 Do you own, rent or live with parents? _____ Total Value of Home \$ _____
 How much is your monthly payment? _____ \$ _____
 Make and Model of Vehicles: Make _____ Year _____
 Make _____ Year _____

6. List any assets and the value, if greater than \$1,000.00

_____	Owe \$ _____
_____	Owe \$ _____
_____	Owe \$ _____
_____	Owe \$ _____

7. Comments _____

I certify that to the best of my knowledge, the above information is true and correct. I understand that if any information I have given proves to be untrue, Baptist Health can deny or reverse any adjustment that may result from this application. I provide Baptist Health Permission to review my credit report or similar financial statements.

9. Applicant Signature _____
 Date: _____

