FINANCIAL INFORMATION FORM / FINANCIAL ASSISTANCE PROGRAM APPLICATION

For assistance completing this form or if you have questions, please call (806) 250-2754

Guarantor Name:	Contact Phone
Patient Name:	
Patient Street Address:	City, State ZIP
Account Number(s):	Date(s) of service:

Instructions: **All questions must be answered. If a question does not apply write N/A on the line.**
Attach a photocopy of a valid proof of identity for each household member.
Attach a photocopy of the following proof of income as applicable:
Attach a photocopy showing proof of residency (i.e. most recent utility bill, or rental agreement)

- O Last two paycheck stubs
- O Social Security check or award letter
- O Unemployment benefit confirmation
- O Most recent Federal income tax return

***** This application is not considered complete without the supporting documentation *****

Marital Status (check one):

O Married O Single O Divorced
O Widowed O Other

Please list all Household Members and their relationship to the Patient/Guarantor

Full Name	Date of Birth	Relationship

Employment

Guarantor/Patient	Spouse/Other Adult
Employer	Employer
Occupation	Occupation
Employment Status (check one) O Full Time O Part-time O Unemployed O Housewife O Unable to return to work	Employment Status (check one) O Full Time O Part-time O Unemployed O Housewife O Unable to return to work

Household Income per Month

Guarantor	$ _____ /mo
Patient	$ _____ /mo
Spouse	$ _____ /mo
Alimony	$ _____ /mo
Unemployment	$ _____ /mo
Child Support	$ _____ /mo
Survivors Benefit	$ _____ /mo
Workers Compensation	$ _____ /mo
Trust Fund(s)	$ _____ /mo
Other	$ _____ /mo
Total Income	$ _____ /mo

Bank Accounts/Other Assets (all 3 questions must be answered):

Checking Account? (circle one)	Yes	No	Current Balance	$ _____
Savings Account? (circle one)	Yes	No	Current Balance	$ _____
Other Property? (circle one)	Yes	No	Current Value	$ _____
If Yes, please describe:	_____			

****Information regarding assets is collected for verification purposes only and will not be used to determine eligibility for the charity program**

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Patient Name:

* I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.

* The information I have provided reflects all HOUSEHOLD income.

* This information as well as other publicly available information may be used by Parmer Medical Center to establish a payment plan and/or to initiate an application for financial assistance and/or to determine eligibility for various programs, coverage or assistance.

* I give my consent to Parmer Medical Center to obtain information from any source to verify the statements I have made.

* I understand that I will receive written communication from Parmer Medical Center if the information provided is incomplete or insufficient to determine my eligibility for financial assistance or if I do not meet the eligibility qualifications. I also, understand that I will be notified in writing if I am eligible for financial assistance.

* I understand that if I do not qualify for financial assistance, I will be responsible for the cost of any services I receive.

* I agree to pay, or make arrangements to pay, the estimated amount due for the services to be performed prior to receipt of those services.

Patient/Guarantor Signature _____ Date _____

*** After completing this application, mail or return it and ALL supporting documents to:

Parmer Medical Center Business Office
Attn: Financial Assistance
1307 Cleveland Ave.
Friona, TX 79035

Office Use Only

Financial Assistance is approved / disapproved (circle one) for this application.

Approved by: _____ Signature _____ Date