Baptist Hospital of SETX-BEAUMONT Financial Information Form

_____ _____
Print Patient Name Account No. or Social Security No.

_____ _____
Print Guarantor/Parent Name(if different from above) Social Security No.

Instructions: All questions must be answered. If a question does not pertain, write N/A on the line. Attach a photocopy of **one of the following** proofs of income to the completed form:

1. Letter of support from friend/family.
2. Last years tax return statement
3. Social Security check or award letter
4. Last 2 paycheck stubs
5. Unemployment or Food Stamp award letter
6. Letter from employer- (to include employee name, hourly wage, number of hours worked.)

PLEASE INCLUDE A COPY OF YOUR RECENT BANK STATEMENT FOR ANY BANK ACCOUNTS YOU MAY HAVE

Citizenship (check one): _____US Citizen _____Non-US Citizen
Marital Status (check one): _____Married _____Single _____Divorced _____Separated _____Widowed
Name of Dependants **(legal deductions on your tax return)** Number in the Household_____

Name:_____Relationship:_____Date of Birth_____
Name:_____Relationship:_____Date of Birth_____
Name:_____Relationship:_____Date of Birth_____
Name:_____Relationship:_____Date of Birth_____
Name:_____Relationship:_____Date of Birth_____

Housing (check one): _____Own _____Rent _____Paid House/Rent Payment $_____/month
Utilities: Electricity $_____/month Gas $_____ /month Water $_____/month
Automobiles: Own (How many?)_____ Lease (How many?)_____ Car Payment (s): $_____/month
Bank Accounts/Other Assets: **(must answer all three questions)** Attach a photocopy of bank statement.
Checking Account? (Circle One) Yes No $_____ Savings Account? (Circle One) Yes No $_____
Additional Assets? (Circle One) Yes No Describe:_____
Include vehicles year/make/model

Employment-PATIENT/GUARANTOR Name of Employer:_____

Employment-SPOUSE Name of Employer:_____

Patient/Guarantor	_____ Employed Full Time	Spouse	_____ Employed Full Time
	_____ Employed Part Time		_____ Employed Part Time
	_____ Not Employed		_____ Not Employed

Other Support

Social Security	$_____/month	Child Support	$_____/month
Trust Fund	$_____/month	Survivors Benefit	$_____/month
Unemployment	$_____/month	Workman's Comp	$_____/month

Total Family Income **$_____ per month (Award requires proof of income with application)**

I hereby declare that the above information is true and correct. If the information supplied is inaccurate or incomplete or the patient's family income exceeds the charity guidelines, I understand that I will be responsible for payment of the entire balance of the bill. I understand this determination is conditional and does not apply to third party claims such as lawsuits, settlements, hospital liens, or any other third party payment or liability. Baptist Hospitals of Southeast Texas retains its rights to recover the full balance of my bill from any third party resource to the fullest extent allowed by law. If my (our) case is selected for Indigent Care classification, I (we) give my (our) consent to the Baptist Hospitals of Southeast Texas to obtain information from any source to verify the statements I (we) have made.

_____ _____
Parent/Guarantor Signature Date