FINANCIAL STATEMENT
STORMONT-VAIL HEALTH*CARE*, Inc.

Hospital		Clinic	
Account #	**$**	**Account #**	**$**
Account #	**$**	**Account #**	**$**
Account #	**$**	**Account #**	**$**
Account #	**$**	**Account #**	**$**
Total Hospital Balance	**$**	**Total Clinic Balance**	**$**

General Information

Patient Name_____ _____ _____
(Last) (First) (M.I.)

Responsible Party/Guarantor_____ Relationship _____

Address _____

City _____ State _____ Zip Code_____

Home Phone (_____)_____ Alternate Phone (_____)_____

Guarantor Employer Name_____Job Title _____

Length of employment at above job_____ F/T or P/T_____ Employer Phone (_____)_____

Spouse Employer Name_____ Job Title_____

Length of employment (spouse) _____ F/T or P/T_____ Spouse Work Phone (_____)_____

Financial Information

Gross monthly income (guarantor)	$ _____
Gross monthly income (spouse)	$ _____
Monthly child support received	$ _____
Monthly alimony received	$ _____
Social Security received	$ _____
Disability received	$ _____
Unemployment received	$ _____
Income from members living in household (other than spouse)	$ _____
Other income (pension, rental, interest, etc)	
Total Monthly Income	$ _____
Total amount in Savings Accounts	$ _____
Total amount in Checking Accounts	$ _____
Total amount in other resources	$ _____

Documentation must be provided for proof of ALL Financial Information.

You must include copies of:

-- most recent Federal Tax Return

-- pay stubs for the last month for you, your spouse and any household members

-- proof of any other income (child support, alimony, social security, disability, unemployment, etc.)

-- copies of last month's bank statements for checking and savings accounts

-- copies of most recent statements for other resources (CDs, money markets, stocks, bonds, mutual funds, pending lawsuits, etc.)

Number of persons supported by Total Monthly Income _____

If different from Federal Tax Form, please explain briefly _____

I certify that the above information is true and accurate to the best of my knowledge and understand that if I submit false information I will not be eligible for Financial Assistance. I verify that the Patient/Responsible Party is a Citizen of the United States **and** has resided in the state of Kansas for the last 6 months.

Signature_____ **Date**_____

Return this form along with the required documents above. Failure to complete this form in full and to provide documentation for proof of ALL Financial Information may result in Financial Assistance denial. Further information may be requested

pending consideration of Financial Assistance. All required information is due back within 14 days of receipt. If you have questions call Customer Service - **(785) 354-1150, (800) 637-4716 or email at: hospitalbillinghelp@stormontvail.org**