PrairieView
Behavioral & Mental Healthcare

Name:______________________________

Prairie View Case Number:________________

FINANCIAL EVALUATION

Date form was given to patient:____________________ PV POC: ____

Total Account Balance: $__________________ Balance of Patient's Personal Responsibility: $__________________

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INSTRUCTIONS: Please complete the following information and *return within 15 days of receipt.*

Responsible Party:______________________________ Spouse's Name:______________________________

Employer:____________________________________ Spouse's Employer:___________________________

Length of Employment:________________ Length of Employment:________________

List Members of Household, including those under age 18 (If more space is needed, please continue in Comments):

	Relationship to Patient or Responsible Party	Full Name	Date of Birth	Claim on Federal Income Tax Y/N)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

MONTHLY INCOME Please indicate *ALL* sources of income, write 0 if not applicable.

	Gross Income	Net Income
Responsible Party's Wages/Tips	$________________	$__________________
Spouse's Wages/Tips	$________________	$__________________
Unemployment Income	$________________	$__________________
Worker's Compensation	$________________	$__________________
Disability Income	$________________	$__________________
Social Security Income	$________________	$__________________

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MONTHLY INCOME CONTINUED

Veterans' Payment	$_____	$_____
Survivor Benefits	$_____	$_____
Pension	$_____	$_____
Retirement Income	$_____	$_____
Child Support	$_____	$_____
Interest/Dividends	$_____	$_____
Royalties	$_____	$_____
Income from rental property	$_____	$_____
Estates/Trusts	$_____	$_____
Alimony	$_____	$_____
Assistance from outside household	$_____	$_____
Other Income: _____	$_____	$_____
TOTAL GROSS Monthly Income	$_____	
TOTAL NET Monthly Income		$_____

Please provide a written explanation of your current financial situation. This information will be used to reach a reasonable determination regarding your account. If you need additional space, please use the back of this form or add additional paper.

Comments:

I certify that the above information is accurate to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services provided by Prairie View. I hereby grant permission to Prairie View to investigate the information contained herein.

Responsible Party/Patient Signature: _____ Date: _____

Relationship to Patient: _____ Phone: _____