

Name:\_\_\_\_\_

Prairie View Case Number:\_\_\_\_\_

## FINANCIAL EVALUATION

INSTRUCTIONS: Please complete the following information and <u>return within 15 days of receipt.</u>						
Total Account Balance: \$	Balance of Patient's Personal Responsibility: \$					
Date form was given to patient:	PV POC:					

 Responsible Party:
 Spouse's Name:

 Employer:
 Spouse's Employer:

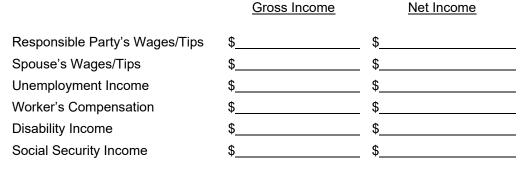
 Length of Employment:
 Length of Employment:

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 <u>ALL</u> sources of income, write 0 if not applicable.



drg; H:/Forms/Financial Evaluation Originated: unknown; Revised: 10/17/2024

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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: