NCH Healthcare System

FINANCIAL INFORMATION REQUEST FORM
Please Complete Front and Back of This Form, Thank You

Please Complete and Mail Form to: **NCH HEATHCARE SYSTEM, INC.**
ATTN: NCH Business Center
P. O. Box 27473
Salt lake City, UT 84127-0473

NCH #158 Front Revised 9/10

Account Number(s)	
Patient's Name (Last, First and Middle Intital)	Patient Social Security Number
Address City State Zip Code	Date of Birth
Years at this Address ☐ Own ☐ Rent (Years) (Months)	Telephone Number
Name of: ☐ Spouse ☐ Parent (Last, First and Middle Intital)	Social Security Number ☐ Spouse ☐ Parent
Address City State Zip Code	Date of Birth ☐ Spouse ☐ Parent

Patient Employer Information	**Spouse or Parent Employer Information**
Employer's Name	Employer's Name ☐ Spouse ☐ Parent
Employer's Address City State Zip Code	Employer's Address City State Zip Code
Employer's Telephone Number	Employer's Telephone Number
Length of Employment / Job Title	Length of Employment / Job Title
Self-Employed? ☐ Yes ☐ No Name of Business	Self Employed? ☐ Yes ☐ No Name of Business
Who pays your expenses if you do not have any income?	
Did you file a tax return this past year?	

Dependents Living in Household Other Than Those Listed Above

Children over the age of 18 years old should not be listed unless school records are provided

Child's Name	**Date of Birth**	**Social Security Number**	**Relationship to Patient**
Other:			

Income Information

								Monthly Gross Income
Patient's Monthly **Gross** Salary			$	OR	Hourly	$	Hrs Worked Weekly	
☐ Spouse's Monthly **Gross**	☐	Parent's Monthly **Gross**	$	OR	Hourly	$	Hrs Worked Weekly	
Monthly Retirement/Pension								$
Monthly Social Security								$
Monthly Unemployment Benefits								$
Monthly Child Support/Alimony								$
Monthly Rental Income								$
Monthly Interest/Dividends								$
Other Monthly Income:								$
Please provide the following:			Total Gross Monthly Income					$

Self Employed: **A copy of your latest tax return (business and individual) required**

Employed: **Copies of your last three (3) paycheck stubs are required**

Unemployed: **Gross monthly income prior to unemployment $ _____ Date unemployment began? ___/___/___**

Assets	YES	NO	BALANCE
Do you own stocks or bonds?			$
Do you have a checking account?			$
Do you have a savings account?			$
Do you have a money market account?			$

Do you own other property than current residence? ☐ Yes ☐ No How many do you own? _____ Address below

Address _____ Address _____

City, State and Zip Code _____ City, State and Zip Code _____

Do you own a car(s)? ☐ Yes ☐ No How Many? _____

Year	Make/Model	Year	Make/Model

Monthly Expenses		Monthly Payment	Balance Owed
Rent/Mortgage (including taxes & insurance)		$	$
Utilities (electric, phone, water, sewer, cable)		$	$
Food/Groceries		$	$
Auto Loan(s)		$	$
Credit Card (s)	Company Name		
		$	$
		$	$
		$	$
		$	$
Medical Bills	Physician/Provider Name		
		$	$
		$	$
Auto Fuel		$	$
Auto Insurance		$	$
Health Insurance		$	$
Medications		$	$
Other Monthly Expenses		$	$
		$	$

Additionally, I understand that in accordance with Florida Statue 817.50 providing false information to defraud a hospital for purposes to obtaining goods or services, is a misdemeanor in the second degree. I agree to repay the NCH Healthcare System for any assistance received or any recovery of funds from either another payor or through subrogation rights.

X _____ _____

Patient Signature **(if minor,** the responsibility party and relationship) Date

X _____ _____

Guarantor Signature (**Required)** Date

X _____ _____

Witness Signature **(Required)** Date