Shannon Medical Center Financial Responsibility Report

Responsible Party

Name _____ DOB_____ SS#_____ Marital Status_____
Address_____ City_____ State _____ Zip_____ Phone_____
Spouse's Name_____ Spouse's DOB _____ Spouse's SS# _____

Patient Information

Patient's Name _____ DOB_____ SS#_____ Patient Account #(s)_____

Dependents

Name of Dependent	Relationship	DOB	Name of Dependent	Relationship	DOB

Employer and Income Information

Responsible Party Employer_____ Occupation_____
Supervisor_____ Phone #_____ How Long_____
Spouse's Employer_____ Occupation_____
Supervisor_____ Phone #_____ How Long_____

List all Sources and Amount of Income: Attach a Copy of Check Stub, Bank Deposit Record and Tax Return

Source	Amount	Verified	Source	Amount	Verified

Responsible Party Financial Information

Home: ☐ Rent ☐ Buy ☐ Own Monthly Payments: $_____

Monthly bills: Utilities, credit cards, auto loans, personal loans, health & auto insurance premiums, outstanding medical bills and monthly prescription expenses*

Creditor	Balance	Payment	Creditor	Balance	Payment

*If monthly bills total more than monthly income, please explain.

Signature

The information above is true and accurate to the best of my knowledge.
Signed_____ Date_____ Witness_____
(Applicant signature) (Patient Counselor)