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 or 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)