

Shannon 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)