PATIENT FINANCIAL STATEMENT

Patient Information

Guarantor/Responsible Party Name (full legal name)	
Patient Name(if other than responsible party)	Patient Account Number
Address (city, state, zip code)	Phone Number
Spouse Name	Phone Number

Employer Information

☐ **Guarantor** ☐ **Patient** ☐ **Spouse** **Employer:**	☐ **Guarantor** ☐ **Patient** ☐ **Spouse** **Employer:**
Address	Address
Phone #	Phone #
Job Title	Job Title
Length of Employment	Length of Employment

Members of Household: Please refer to cover letter to determine members of household.

Name	Date of Birth	Relationship to Patient

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Income: Please refer to cover letter to determine income.

Source of Income	Household Member	Amount Received	W-Weekly B-Biweekly M- Monthly A-Annually

Banking and Investments: Include all bank accounts, savings accounts, retirement accounts (IRA, Pension Fund, 401k, 403b, etc), money markets, mutual funds, etc.

Banking/Investments	Amount	Comments

Other Assets: Includes real or personal property EXCEPT patient home (primary residence) and personal vehicles. Examples of assets to include are rental property, vacant lots, farm acreage, business property, vacation property, boats, motor homes, all terrain vehicles, etc.

Property	Estimated Value	Amount Owed on Property	Net Value

Please explain why you are requesting financial assistance. If you are not able to provide requested documentation please explain why.

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If your income/lifestyle has changed, please explain and provide documentation (i.e. loss of job, death in the family, divorce, extraordinary medical bills or other expenses, etc.)

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This Patient Financial Statement should be signed and dated by all applicable parties in order to process your application.

I represent that the information provided is true and accurate to the best of my knowledge. HALO-Flight, Inc is hereby authorized to obtain a credit report in connection with the social security number which I, as payor and signer of this form, certify to be my legally assigned individual social security number.

_______________________________ Signature of Patient or Responsible Party

_____________________ Social Security Number

Date: _________

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