Tri-State Pulmonary Associates, Inc.

CONFIDENTIAL FINANCIAL WORKSHEET

Patient Name: _____ Responsible Party: _____
Address: _____
City, State, Zip: _____
Telephone: _____
Cell Telephone: _____
Place of Employment:
Patient: _____ Spouse: _____
Number of persons living in your home: _____

MONTHLY INCOME
Patient's Income _____
Spouse's Income _____
Father's Income (if minor) _____
Mother's Income (if minor) _____
AFDC _____
Child Support _____
Social Security _____
Pension _____
SSI/Disability _____
Food Stamps _____
Other Income (please explain)
_____

MONTHLY EXPENSES
Rent/House Payment _____
Car/Truck Payments _____
Utilities (electric, phone, gas, water) _____
Car Insurance _____
Health/Dental Insurance _____
Life Insurance _____
Property Insurance _____
Property Tax _____
Medical Fees (Dr, Rx, Hospital) _____
Food/Clothing _____
Other (child care, bus, etc...) _____
Loan Payments (credit, school,etc)_____

TOTAL MONTHLY INCOME $ _____ **TOTAL MONTHLY EXPENSES $_____**

Remarks (use additional sheet, if necessary):_____

Name of PRIMARY Insurance Company_____ Policy #_____
Phone Number_____

Name of SECONDARY Insurance Company_____ Policy #_____
Phone Number_____

Have you applied for Ohio Medicaid? _____ If yes, when:_____

I certify that the above information is true and accurate and that this application is made to enable TSPA, its parent, affiliates and/or subsidiaries to judge your eligibility for reduced out-of-pocket medical expenses. If any of the information given proves to be untrue, TSPA may re-evaluate your financial status and take action necessary to collect on your account.

Application Signature_____

Date_____