ST VERONICA
SENIOR BEHAVIORAL HEALTH HOSPITAL
AT CATHOLIC CARE CENTER

Name:______________________________________

SVSBH Case Number:______________________

FINANCIAL EVALUATION

Date form was given to patient:_____________________

Total Account Balance: $___________________ Balance of Patient's Personal Responsibility: $___________________

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INSTRUCTIONS: Please complete the following information and *return within 15 days of receipt.*

Responsible Party:________________________________ Spouse's Name:____________________________________

Employer:_______________________________________ Spouse's Employer:________________________________

Length of Employment:__________________ Length of Employment:__________________

Number of Dependents claimed on Federal Income Tax Form:________________

Age of Dependents: ________, ________, ________, ________, ________, ________, ________, ________, ________, ________

ASSETS

	Estimated Value	Unpaid Balance
Residence	$___________________	$___________________
Vehicles	$___________________	$___________________
Farm	$___________________	$___________________
Business	$___________________	$___________________
Rental Property	$___________________	$___________________
Recreation Vehicle	$___________________	$___________________
Other:__________________	$___________________	$___________________
Other:__________________	$___________________	$___________________

OTHER ASSETS

Financial Institution:____

Address:____

____

Checking Account Balance:	$_____________________	as of: (Date)___________________
Savings Account Balance:	$_____________________	as of: (Date)___________________
Savings Certificates:	$_____________________	as of: (Date)___________________
Other Investments:	$_____________________	as of: (Date)___________________

Name:_____

SVSBH Case Number:_____

MONTHLY INCOME Please indicate *ALL* sources of income.

	Gross Income	Net Income
Responsible Party's Income	$_____	$_____
Spouse's Income	$_____	$_____
Unemployment Income	$_____	$_____
Disability Income	$_____	$_____
Child Support	$_____	$_____
Other Income:_____	$_____	$_____

TOTAL *GROSS* Monthly Income $_____

TOTAL *NET* Monthly Income $_____ ***1**

MONTHLY EXPENSES Please indicate *average* expenses for the following items.

Groceries	$_____
Utilities: Electric/Gas/Propane	$_____
Water / Trash	$_____
Telephone	$_____
Gas for Vehicle(s)	$_____
Child Care	$_____
Cable / Internet	$_____
Clothing	$_____
Other:_____	$_____
Other:_____	$_____

SUB-TOTAL of Average Monthly Expenses $_____ ***2**

CREDITORS Please list Creditor's name and *ALL* monthly payments.

	Name	Unpaid Balance	Monthly Payment
Rent / Mortgage:	_____	$_____	$_____
Medical-			
Hospital:	_____	$_____	$_____
Doctor:	_____	$_____	$_____
Doctor:	_____	$_____	$_____
Vehicle Loan:	_____	$_____	$_____
Insurance-			
Vehicle:	_____	$_____	$_____
Health:	_____	$_____	$_____
Life:	_____	$_____	$_____
Other:	_____	$_____	$_____
School Loans:	_____	$_____	$_____
Other Loan:	_____	$_____	$_____

Name:_____

SVSBH Case Number:_____

Credit Cards –	Total Amount Owed	Monthly Payment
Visa	$_____	$_____
MasterCard	$_____	$_____
Discover	$_____	$_____
American Express	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____

SUB-TOTAL of ALL Monthly Payments to Creditors $_____ ***3**

TOTAL MONTHLY EXPENSES (*2 plus *3) $_____ ***4**

INCOME LESS TOTAL MONTHLY EXPENSES (*1 minus *4) $_____

Please provide a written explanation of your current financial situation. This information will be used to reach a reasonable determination regarding your account. If you need additional space, please use the back of this form or add additional paper.

Comments:_____

I certify that all information is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services provided by St. Veronica Senior Behavioral Health Hospital at Catholic Care Center (SVSBH). I hereby grant permission to SVSBH to investigate the information contained herein.

Responsible Party/Patient
Signature:_____ Date:_____