# FINANCIAL EVALUATION

| PATIENT'S LAST NAME<br>APELLIDO DE PACIENTE | FIRST<br>PRIMERO | MIDDLE<br>SEGUNDO | SOC SEC #<br>SEGURO SOCIAL | BIRTH DATE<br>FECHA DE NACIMIENTO | LEGAL CITIZEN Y/N<br>CIUDADANO LEGAL SI/NO |
|---|---|---|---|---|---|
| MAILING ADDRESS (DIRECION) | CITY (CIUDAD) | STATE (ESTADO) | ZIP (CODIGO POSTAL) | PHONE (NUMERO DE TELEFONO) | |
| LAST NAME (RESPONSIBLE PARTY)<br>APELLIDO (DE RESPONSABILIDAD) | FIRST<br>PRIMERO | MIDDLE<br>SEGUNDO | SOC SEC #<br>SEGURO SOCIAL | BIRTH DATE<br>FECHA DE NACIMIENTO | |
| RESPONSIBLE PARTY EMPLOYER (NAME & FULL ADDRESS)<br>EMPLEADOR DE ADULTO RESPONSABLE (NOMBRE Y DIRECTION) | PHONE<br>NUMERO DE TELEFONO | MONTHLY NET PAY<br>INGRESO MENSUAL $ | | | |
| SPOUSE'S LAST NAME<br>APELLIDO (DE ESPOSO/A) | FIRST<br>PRIMERO | MIDDLE<br>SEGUNDO | SOC SEC #<br>SEGURO SOCIAL | BIRTHDATE<br>FECHA DE NACIMIENTO | |
| SPOUSE'S EMPLOYER (NAME & FULL ADDRESS)<br>EMPLEADOR DE ESPOSO/A (NOMBRE Y DIRECION) | PHONE<br>NUMERO DE TELEFONO | MONTHLY NET PAY<br>INGRESO MENSUAL $ | | | |

**Is any family member in the house currently on AHCCCS or other Medicaid program?** (ALGUIEN EN LA FAMILIA RECIVE AHCCCS? SI/NO) **Y / N** ☐

**FAMILY MEMBERS:** (MIEMBROS DE FAMILIA) **HOUSEHOLD SIZE: (TOTAL DE PERSONAS QUE VIVEN EN EL CASA):** ____________

| | NAME<br>NOMBRE | BIRTHDATE<br>FECHA DE NACIEMENTO | RELATIONSHIP<br>RELACION | AGE<br>EDAD | LEGAL RESIDENT/CITIZEN Yes/No:<br>RESIDENTE/CUIDANO DE ARIZONA SI/NO |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |

**INCOME FREQUENCY OPTIONS**(OPCIONES DE FREQUENCIA DE INGRESO):

**WEEKLY** (SEMANA) ☐ **BIWEEKLY** (CADA DOS SEMANAS) ☐ **MONTHLY** (MENSUAL) ☐ **SEMI-MONTHLY** (QUINCENAL) ☐

**GROSS AMOUNT PER PAYDAY: Mom/Frequency: $_________/_________ Dad/Frequency: $_______/_________OTHER INCOME $ __________**
(INGRESO BRUTO ANTES DEDUCIONES) (MADRE /Frequencia) (PADRE/ Frequencia) **(OTRO INGRESO)**

**TOTAL MONTHLY GROSS INCOME: $__________________ TOTAL YEARLY GROSS INCOME $__________________________**
**(INGRESO TOTAL MENSUAL)** **(INGRESO TOAL AL ANNUAL):**

**I do not have income, I maintain myself in this manner: Aid of the family or/and friends**
(NO TENGO INGRESOS; ME SOSTENGO DE ESTA MANERA: AYUDA DE FAMILIARES Y/O AMIGOS)

**IN KIND PROVIDER:** ________________________________ **ADDRESS:** ____________________________________
(PROVEEDOR DE LA MISMA AYUDA) (DIRECCION)

**LIQUID ASSETS (ACTIVOS LIQUIDOS):** ____________________ **RESOURCES (RECURSOS):** ______________________

| BALANCE (BALANCE) | CASH VALUE (VALOR EN EFECTIVO) | MARKET VALUE/BALANCE OWED (VALOR / BALANCE QUE SE DEBE) |
|---|---|---|
| **CASH ON HAND:** Y/ N $ ___________<br>EFECTIVO DISPONIBLE: SI/ NO | **STOCKS/BONDS**:Y/N $ _______________<br>ACIONES/BONOS : SI / NO | **REAL PROPERTY** Y/N $ __________ $ ___________<br>PROPRIEDAD: SI/ NO |
| **CHECKING** Account: Y/N $__________<br>CUENTA CORRIENTE: SI/ NO | **SAVING** Account:: Y/N $__________<br>CUENTA DE AHORROS: SI/ NO | **VEHICLE**: Y/ N☐ $ ___________ $ ____________<br>VEHICULO: SI/ NO |
| **IRA/OTHER:** Y/N $ _______________<br>RETIRO: SI/ NO | **LIFE INSURANCE**: Y/ N $ ___________<br>SEGURO DE VIDA: SI/ NO | **PREPAID BURIAL**:Y/N $ ________ $ ___________<br>PREPAGADO: SI/ NO |

**MONTHLY EXPENSES (GASTOS MENSUALES):**

RENT/MORTGAGE (TENTA/HIPOTECA) $ ____________ FOOD (COMIDA)$ ____________ UTILITES (UTILIDADES) $ ____________
AUTO EXPENSES (GASTOS DE VEHICULOS) $____________ CREDIT CARDS (TARJETAS DE CREDITO) $ ____________
OBLIGATIONS (OTRAS OBLIGACIONES) $ ____________ TOTAL MONTHLY MEDICAL BILLS (Cobros médicos mensual) $____________

**TOTAL MONTHLY EXPENSES $** _______________ **TOTAL MONTHLY PAMENT FOR ALL EXPENSES: $**_________________
(TOTAL DE GASTOS MENSUALES ) (TOTAL DEL PAGO MENSUAL POR TODOS LOS COBROS)

***I swear and affirm that all statements made on this application are true and correct. You are hereby authorized to check my credit history in order to evaluate this financial statement. (Yo juro y afirmo que todas las declaraciones son verdaderas y correctas. Yo autorizo que verifiquen mi historial de crédito para evaluar mi situación financiera.)***

______________________________________________________________________

**Parent/ Guardian Signature REQUIRED / (Firma de Padre/Guardian REQUERIDO) Date (Fecha)**

**PHOENIX CHILDREN'S HOSPITAL**

Patient Name:

Patient Account Number:

When applying for charity assistance for services rendered you are affirming that all statements made on the application are true and correct.

**Receipt of this application is not a guarantee that an extended payment plan or financial assistance will be approved. During the application review process, payments must continue on a regular (monthly) basis to avoid the possibility of referral to collections.**

Phoenix Children's Hospital consideration of your application for Financial Assistance is requires that **All** of the following documents be received within 30 days with the signed Financial Evaluation:

- ☐ Completed, signed and dated Financial Evaluation
- ☐ A copy of Prior Year Tax Return - including all schedules
- ☐ A copy of Current Pay Stubs (2 months)
- ☐ Copies of the following forms of income that apply: Social Security, Disability, or Unemployment Checks or award letter
- ☐ If unemployed, provide the reason for unemployment:
  ( ) Lay-Off ( ) Quit ( ) Retired ( ) Last Place Worked ____________________
  ( ) Terminated: Date of Termination __________
  ( ) Disable: Date of Disability __________
- ☐ A copy of your last two months bank statements for all accounts (checking and savings).
- ☐ A copy of any outstanding medical bills, including doctor bills, ambulance, etc.

**Mail completed form and document to:**

**Phoenix Children's Hospital,**
**P O Box 743421**
**Los Angeles, CA 90074-3421**

For questions regarding the financial assistance application process, please call (602) 933-8700 between 9:00 am and 3:00 pm.

Sincerely,
Phoenix Children's Hospital

July 2014