



PFFIN

Patient Name: _____ DOB: _____ Date: _____

Permanent Address: _____ City: _____ ZIP: _____

State: _____ Hm Phone: _____ Wk Phone: _____

Mailing Address if Different:

Address: _____ City: _____

State: _____ ZIP: _____

Employer Name: _____ Employer Ph: _____

Employer Address: _____

- 1 Have you applied for financial aid or completed this form in the last 90 days? Yes No
- 2 Do you currently have any type of health insurance? Yes No
- 3 Was your provider visit a result of an accident at work? Yes No
- 4 Was your provider visit a result of an auto accident? Yes No
- 5 Is your primary residence outside of the US? Yes No

If you answered YES to ANY of the questions above, STOP. Contact the Business Office of the Baptist facility where services were received to discuss your account.

For the following table, please list the patient and all family members living in the same household as the patient. Family members are persons related by birth, marriage, or adoption. Include the relationship and age of all family members. Then, list the amount and source of each person's income. Income includes gross (pre-tax) wages, rental income, unemployment compensation, social security, retirement, disability benefits, public assistance, etc. Documentation supporting the income calculations must be submitted with this signed application.

Family Member (Name)	Relationship to Patient	Age	Source of Income or Employer Name	Last Three Months Pay Stubs	Income for 12 Months Tax Return
Total Family Members			Total Income		

Your application cannot be processed unless you provide one of the following documents to support each source of income listed above.

- Pay stubs for the last three months
- W2 Form for the previous year
- Legal documents/Child Support
- Bank Statements
- Income Tax return for the previous year
- Federal & State Assistance Documents
- Pension/retirement statements

Please return this application and the requested information to the Business Office of the Baptist facility where services were received.

I certify that the information provided is true and accurate to the best of my knowledge.

Signature of Patient, or Person Authorized to Sign for Patient _____ Relationship to Patient _____

Date _____ Place of Service _____ Hospital or _____ Physician _____

FOR PROVIDER USE ONLY

Account Number _____ Date of Service _____

BMHCC Provider _____



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FINANCIAL APPLICATION

▼ Patient Label ▼