SHEPHERD CENTER- PATIENT FINANCIAL EVALUATION

Patient's Name_____ DOB_____

Guarantor Name *(if not patient)*_____ Date of Application_____

Address_____ City, State, Zip_____

Guarantor Employer_____

Number you claim on income taxes _____ (for dependents under the age of 18 or dependents in college under the age of 26)

☐ Single ☐ Married: If married, how many people in household you pay at least half of their living expenses: _____ (This will include guarantor, spouse and dependent children)

CURRENT INCOME: Per Month/Year (Gross)

Patient Employment Income: $_____ ****Proof of income must be attached**

Spouse or Guarantor Emp Income: $_____ ****Proof of income must be attached**

Other Income: (List Source) Examples, Social Security, Disability, Worker's Comp etc.

1. _____ $_____ ****Proof of income must be attached**

2. _____ $_____

****Proof of income can be paystubs, bank statement, letter from employer, disability determination letter.**

Total Monthly Income $_____ ****If zero and there is no spouse income, must provide room & board letter from person providing basic living expenses to patient.**

PRIOR to INJURY INCOME (No proof required)

Patient $_____

Spouse or Guarantor $_____

RESOURCES:

Do you own your home? ☐ No ☐ Yes (If yes) Estimated Value of Home: $_____

Outstanding Loan Amt: $_____

Checking Account Balance: $_____ Savings Account Balance $_____

Investments/Dividends/Interest, etc. $_____

CURRENT DEBT: Total Amount of Debt other than home mortgage: $_____

FOR SHEPHERD EMPLOYEE TO COMPLETE:

Shepherd Center Employee's Name:_____ Date:_____

Level of Care: Services requested Reason

SCI___ ABI___

Inpt.:_____ _____

Day Pt:_____ _____

Outpt:_____ _____

Other:_____ _____

Has patient applied for GA Medicaid? ☐ Yes ☐ No Is patient covered by COBRA? ☐ Yes ☐ No

Is patient eligible for OOS Medicaid? ☐ Yes ☐ No If yes, what state?_____

APPROVALS from Program Director & PFS Manager

☐<125% FPG ☐>125%-250% FPG ☐ >250% FPG+ Expenses

Use of Funds Approved by:_____ Date:_____

Qualification Approved by:_____ Date:_____

Patient Agreement:

I understand that the information I have provided will be utilized to assess my ability to pay for services rendered at Shepherd Center and/or to determine my eligibility for financial consideration/assistance. I affirm the above information is true & correct. If requested, I will provide additional information and documentation to further assist in the evaluation of my request for assistance. I agree to cooperate with Shepherd Center with regard to identification and assistance with collection of any other payment sources. I agree that misrepresentation of information on this form will result in forfeiture of financial assistance. (Completion of this agreement does not guarantee approval for financial assistance.)

Signature & Date: _____ Witness & Date: _____