

PARKVIEW MEDICAL GROUP - CHARITY APPLICATION

Account #:		Account Balance:		
------------	--	------------------	--	--

SECTION I: Applicant Information

Last Name	First Name	M.I.	Phone Number ()	
			Cell Number ()	
Address			City/Zip	

Household Members (First & Last Names)	Relation Code	Birthdate	Social Security or ID#
APPLICANT			

Relation Codes: 1 Self 2 Spouse 3 Child 4 Stepchild 5 Other

MONTHLY FINANCES:

What I owe:			What I owe:		
Creditor	Monthly Pmt	Additional Information	Creditor	Monthly Pmt	Additional Information
Credit Cards	\$		Utilities	\$	
Auto Insurance	\$		Gas & Oil	\$	
Auto Loan	\$		Groceries	\$	
Home Mortgage/Rent	\$		Health/Life Insurance	\$	
Finance Company/Loans	\$		Monthly Medical Expenses	\$	
Child Support/Day Care	\$		Misc	\$	

Checking Account / Bank Name	Savings Account / Bank Name

SECTION II: Calculating Income and Resources

INCOME SOURCE	Monthly Amount	Annualized Total	EQUITY IN RESOURCES	Actual Value	Minus Amount Owed	Equals Equity	Minus Protected	Equity Calculation
1. Net Employment Income	\$	\$	7. Vehicle Equity Make/Model			\$		
2. Self Employment Income	\$	\$	8. Real Property			\$	\$	
3. Unearned Income	\$	\$	9. Liquid Resources			\$	\$	
4. Total Income (Lines 1+2+3)	\$	\$	10. Business Equity			\$	\$	
5. Monthly Expense or In Kind Income	\$	\$	11. Total Equity (Lines 7+8+9+10)					
			12. Less Family Size Deduction	Family Size	1	X \$		
			13. Equity Resources Calculation (Line 11 minus line 12; cannot be a negative number)					
Authorized by:			14. Total Family Financial Status					
Date			15. Minus Allowable Deductions:					
			16. Equals Income and Equity in Resources (Line 14 minus Line 15)					-

Additional Comments:

Print or Type Applicant Name

Print or Type Patient Financial Representative Name

Parkview Medical Group Physician Business Services

Print or Type Facility Name

TOTAL CHARGES	
ADJUSTMENT	
TOTAL DUE	0.00

Applicant Signature and Date

Patient Financial Rep Signature and Date

719-595-7580

Facility Phone Number