DOCTORS COMMUNITY HEALTH SYSTEM

8118 Good Luck Road
Lanham, Maryland 20706

FINANCIAL SCREENING FORM

(Please Print Legibly)

Patient Name _____ SS# _____-_____-_____

Patient Address _____

City _____ State _____ ZIP Code _____

Birth Date ____ / ____ / ____ Home Phone No. ( ) _____ - _____ Home Phone No. ( ) ____ - _____

Spouse Name (if applicable) _____ SS# _____-_____-_____

Spouse Address _____

City _____ State _____ ZIP Code _____

Birth Date ____ / ____ / ____ Home Phone No. ( ) _____ - _____ Home Phone No. ( ) ____ - _____

LIST ALL CHILDREN UNDER 21 YEARS OF AGE

Child's Name _____ Birth Date ____ / ____ / ____

Child's Name _____ Birth Date ____ / ____ / ____

Child's Name _____ Birth Date ____ / ____ / ____

Child's Name _____ Birth Date ____ / ____ / ____

Child's Name _____ Birth Date ____ / ____ / ____

RESPONSIBLE PARTY INFORMATION (Do NOT Complete if Patient Is Responsible Party)

Responsible Party Name _____ SS# _____-_____-_____

Patient Address _____

City _____ State _____ ZIP Code _____

Birth Date ____ / ____ / ____ Home Phone No. ( ) _____ - _____ Home Phone No. ( ) ____ - _____

EMPLOYMENT INFORMATION

Place of Employment _____

Address _____

City _____ State _____ ZIP Code _____

Telephone No. ( ) _____ - _____ Extension _____ Supervisor Name _____

INSURANCE INFORMATION

Do you have health insurance? . . . . . ❑ Yes ❑ No

If YES, Name of Company _____ Policy # _____

Have you ever applied to a state medical assistance program? . . . . . ❑ Yes ❑ No

If YES, Name of State _____ Birth Date _____ / _____ / _____

Did you receive assistance from the state? . . . . . ❑ Yes ❑ No

FINANCIAL SCREENING FORM

(Please Print Legibly)

Please provide proof of income and expenses with this application.

They can include last 2 pay stubs, W-2 forms, bank statements, utility bills, mortgage statements.

MONTHLY INCOME

	GROSS	NET
Patient Salary	_____	_____
Spouse/Other	_____	_____
Soc. Sec. Income	_____	_____
Disab. Income	_____	_____
Pension Income	_____	_____
Interest Income	_____	_____
Unemployement	_____	_____
TOTAL	_____	_____

OTHER MONEY RECEIVED

Alimony	_____	_____
Child Support	_____	_____
Other	_____	_____
TOTAL	_____	_____

OTHER ASSETS

Name of Bank (Checking) _____
Account # _____
Name of Bank (Savings) _____
Account # _____

Name of Bank (Checking) _____
Account # _____

Name of Credit Union _____
Account # _____

Other Bank Account(s) _____
_____

Do you own stocks? . . . . . ❑ Yes ❑ No
Do you own bonds? . . . . . ❑ Yes ❑ No
Do you own property? . . . . . ❑ Yes ❑ No

I have answered the questions in this application correctly to the best of my recollection and based on my records. I understand that the Account Review Committee at Doctors Community Health System may request additional information from credit reporting agencies, employers and other third parties.

Applicant Signature _____

Date of Application _____

MONTHLY EXPENSES

Rent/ Mortgage _____
To Whom Paid _____
Telephone No. ( ) ____ - _____ Ext. ____
Auto Payment _____
Year _____ Make _____ Model _____
Financed By _____
Phone No. ( ) _____ - _____ Ext. ____
Electricity _____
Gas Utility _____
Telephone _____
Alimony _____
Child Support _____
Credit Cares (See Below) _____
Medical/Dental (See Below) _____
TOTAL _____

DOCUMENT CREDIT CARDS & MEDICAL/DENTAL

List Credit Cards

Account # _____
Account # _____
Account # _____

List Medical / Dental

_____ _____
_____ _____
_____ _____

Other Expenses

_____
_____
_____
_____
_____
_____
_____
_____