**Financial Disclosure Form**

In order to accurately assess your ability to pay, we ask that you complete this form and return it to us. Also, provide copies of your last 2 check stubs issues within the last 90 days and last year’s federal income tax return, signed and dated, and W2’s for all working household members. Please include documentation for social security, pension funds, support payments, unemployment, …etc. We have enclosed a return envelope for your convenience. Please print or type the information. We appreciate your cooperation.

**Patient:**

**Account#:**

Are you employed? No/Yes (circle one)

If so, Full or Part-time (circle one)

If so, who is your employer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer’s Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single/Married (circle one)

If married, is your spouse employed? Yes/No (circle one)

If so, who is spouse’s employer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years of Service \_\_\_\_\_\_\_\_\_

Employer’s address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer’s Phone \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of dependents as shown on your tax return: \_\_\_\_\_\_\_\_\_\_\_\_

Net income: Per Month Additional Income

Head of Household $\_\_\_\_\_\_\_\_\_\_\_ IRA $\_\_\_\_\_\_\_\_\_\_\_

Spouse $\_\_\_\_\_\_\_\_\_\_\_ 401K Plan $\_\_\_\_\_\_\_\_\_\_\_

Other (describe) $\_\_\_\_\_\_\_\_\_\_\_ Certificate of Deposit $\_\_\_\_\_\_\_\_\_\_\_\_

Total income $\_\_\_\_\_\_\_\_\_\_\_\_ Credit Union $\_\_\_\_\_\_\_\_\_\_\_\_

Assets: Total Savings/checking Account Balance(s): $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you own your own home or rent? Own/Rent (circle one)

Expenses Per Month

Food $ \_\_\_\_\_\_\_\_\_\_/ month

Rent/Mortgage $\_\_\_\_\_\_\_\_\_\_\_ Gasoline $\_\_\_\_\_\_\_\_\_\_/month

Assessed Value of Home $\_\_\_\_\_\_\_\_\_\_\_ Phone $\_\_\_\_\_\_\_\_\_\_/month

Car(s) Make Year Model Credit Cards $\_\_\_\_\_\_\_\_\_\_/month

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heat $\_\_\_\_\_\_\_\_\_/month

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Electric $\_\_\_\_\_\_\_\_\_/month

MC/ins premiums $\_\_\_\_\_\_\_\_/month

We MUST have official, written verification of income in order to process your application, such as both pages of your federal tax return (signed and dated), W2 and/ or recent check status.

Other Expenses (Please list) Hospital, Medical or Pharmacy Expenses

(Please attach copies of these bills)

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Have you received recent hardship write-off by a hospital or other provider? Yes/No (circle one)

If yes, what hospital or provider? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If yes, please include a copy of the approval letter.**

Please briefly explain why you feel you are unable to pay the balance on your bill:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Responsible Party’s Signature Date

We must have official, written verification of income in order to process your application, such as both pages of your federal tax return (signed and dated), W2 and/or recent check stubs.

MAIL TO: Rockford Nephrology

Attn: Dana

612 Roxbury Rd

Rockford, IL 61107