## MEMORIAL HEALTHCARE SYSTEM Financial Evaluation Form

Account Number				MR Number		
Patient's Name:						
Street Address:				Telephone#:		
City:	et Address: State:			Zip:		
Please provide the following inform accordance with Florida Statute purpose of obtaining goods or s	Section	n 817.50, provi	ding false	e information to	defraud a hospital for the	
List of household Members		Date of Birth		ationship to Patient	Employer	
Monthly Income			Mont	thly Expenses		
Responsible Party's Gross Salary	\$		Rent or Own		\$	
Spouse's Gross Salary	\$		Electricity		\$	
Other Income:	\$		Phone		\$	
Assets				٦		
Checking Account		\$		_		
Savings/Money Market/CD's	\$					
Value of Residences(s)		\$				
I certify that the information provided above additional insurance coverage for this patie will result in denial of the application for an Healthcare System. If I am entitled to any a by Memorial Healthcare System to obtain a Memorial Healthcare System, all amounts such assistance or to follow through with the Healthcare System will result in the denial through the credit bureau, if deemed approximations and the state of the system will result in the denial through the credit bureau, if deemed approximations and the system will result in the denial through the credit bureau, if deemed approximations are similar to the system will result in the denial through the credit bureau, if deemed approximation is such as the system will result in the denial through the credit bureau, if deemed approximation is such as the system will result in the denial through the credit bureau, if deemed approximation is such as the system will result in the denial through the credit bureau, if deemed approximation is such as the system will result in the denial through the credit bureau, if deemed approximation is such as the system will result in the denial through the credit bureau, if deemed approximation is such as the system will result in the denial through the credit bureau, if deemed approximation is such as the system will result in the denial through the credit bureau, if deemed approximation is such as the system will result in the denial through the credit bureau, if deemed approximation is such as the system will result in the denial through the system will result in the denial through the credit bureau, if deemed approximation is such as the system will result in the denial through the system will result in the syst	ent other t y type of t action aga such assis recovered ne applica of this ap	han what was liste financial assistance and will ass tup to the total am tition process or tak	d at time of e through th from third pa ign to Memo count of the te those acti	registration. I unders e South Broward Ho arty payors, I will take orial Healthcare Syst outstanding balance ons reasonably nece	stand that providing false information spital District d/b/a Memorial e any action necessary or requester em, and upon receipt will pay to on my bill. My failure to apply for essary or requested by Memorial	
Signature of Patient (Responsible Party)		Date		[Label]		
Witness		Date				

2310-10040 (5-19)