FINANCIAL STATEMENT PROFILE

Mail to: Emory Hospitals
Attn: Customer Service
PO Box 406864
Atlanta, GA 30384

Name:____ SS#:_____________________________

Street Address:____

City:__________________ State:___________ Zip:_______ Contact Phone#:___________________

Employer:____ Years Employed:__________________

Are you married? ___ Yes ___ No Spouse's Name:______________________________

Number of Dependents *(include yourself)*:______ Ages:_______________________________________

PATIENT'S INCOME INFORMATION

Salary: $_____________

Is this amount:___ Hourly ___ Monthly ___Yearly

Unemployment: $________________________

Social Security or Disability: $________________

AFDC: $__________Child Support: $___________

Annuities /Stocks / CD's / Pensions / 401K/403B / Retirement Distributions $__________________

Savings Account: $_______________________

Checking Account: $______________________

Other: $_________________________________

SPOUSE'S INCOME INFORMATION

Salary: $_____________

Is this amount:___ Hourly ___ Monthly ___Yearly

Unemployment: $________________________

Social Security or Disability: $________________

AFDC: $__________Child Support: $___________

Annuities /Stocks / CD's / Pensions / 401K/403B / Retirement Distributions $__________________

Savings Account: $_______________________

Checking Account: $______________________

Other: $_________________________________

OTHER HOUSEHOLD INCOME

Unemployment: $_____________Social Security or Disability: $_____________AFDC:$___________________

Child Support: $______________ Saving Account: $_______________Checking Accounts$________________

Other: $____

MONTHLY HOUSEHOLD EXPENSES

Mortgage/Rent: $____________ Automobiles: $_____________Gas: $_____________ Electric: $_________

Water: $____________________Waste Disposal: $___________ Telephone: $________ Cable: $__________

Groceries: $_________________ Medical/Drugs: $____________Other: $_____________________________

PLEASE SUBMIT THE FOLLOWING WITH THIS FORM:

___ Last Two Pay Stubs ___ Bank Statements for the previous two months

___ Last years Tax Return ___ Income Award Letter

THE PRECEDING INFORMATION IS TRUE AND CORRECT:

Signature: ____ Date:______________

Any misrepresentation of the above information may result in the retroactive denial or reduction of financial assistance and the patient/guarantor being held liable. In addition, Emory Healthcare reserves the right to evaluate a patient's eligibility under the Emory Healthcare Financial Assistance Policy from time to time and to adjust the patient's account as necessary.