COMMUNITY
HEALTH PARTNERS

FINANCIAL EVALUATION

General Information

Account # _____

Community Health Partners Practice Name: _____

Address_____

Phone # _____

Patient Name _____ Guarantor Name _____

Spouse's Name _____

Home Address_____ Monthly Payment _____

_____ ☐ Renting

_____ ☐ Buying

Guarantor

Date of Birth _____ Driver's License # _____ Social Security # ____-_____-____

Employer _____ Department/Position _____

Gross Pay _____ Child Support _____ Social Security _____

Pension _____ Welfare _____ Unemployment _____

Spouse

Date of Birth _____ Driver's License # _____ Social Security # ____-_____-____

Employer _____ Department/Position _____

Gross Pay _____ Child Support _____ Social Security _____

Pension _____ Welfare _____ Unemployment _____

Disability _____ Alimony _____ Interest/Dividends _____

Rents Received _____ Other _____

Where to you bank? _____ Branch, City_____

☐ Checking

☐ Savings

Gross income as reported to the IRS last year _____

Number of dependents under 18 years old living with you _____

Do you provide support for anyone over the age of 18? ☐ No ☐ Yes (Please explain)

_____

I HEREBY CERTIFY THAT ALL STATEMENTS MADE ON THIS FORM ARE TRUE AND CORRECT AND I UNDERSTAND THAT COMMUNITY HEALTH PARTNERS RESERVES THE RIGHT TO VERIFY THE ABOVE.

Guarantor Signature _____ Date _____