NCH Healthcare System

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Please Complete Front and Back of This Form, Thank You

Please Complete and Mail Form to: **NCH HEATHCARE SYSTEM, INC.**
ATTN: Central Campus Business Office
P. O. Box 8569
Naples, FL 34101

NCH #158 Front Revised 9/10

Account Number(s)

Patient's Name (Last, First and Middle Intital)	Patient Social Security Number
Address City State Zip Code	Date of Birth
Years at this Address ☐ Own ☐ Rent (Years) (Months)	Telephone Number
Name of: ☐ Spouse ☐ Parent (Last, First and Middle Intital)	Social Security Number ☐ Spouse ☐ Parent
Address City State Zip Code	Date of Birth ☐ Spouse ☐ Parent

Patient Employer Information	**Spouse or Parent Employer Information**
Employer's Name	Employer's Name ☐ Spouse ☐ Parent
Employer's Address City State Zip Code	Employer's Address City State Zip Code
Employer's Telephone Number	Employer's Telephone Number
Length of Employment / Job Title	Length of Employment / Job Title
Self-Employed? ☐ Yes ☐ No Name of Business	Self Employed? ☐ Yes ☐ No Name of Business
Who pays your expenses if you do not have any income?	
Did you file a tax return this past year?	

Dependents Living in Household Other Than Those Listed Above

Children over the age of 18 years old should not be listed unless school records are provided

Child's Name	Date of Birth	Social Security Number	Relationship to Patient
Other:			

Income Information

						Monthly Gross Income	
Patient's Monthly **Gross** Salary	$	OR	Hourly	$	Hrs Worked Weekly		
☐ Spouse's Monthly **Gross** ☐ Parent's Monthly **Gross**	$	OR	Hourly	$	Hrs Worked Weekly		
Monthly Retirement/Pension				$			
Monthly Social Security				$			
Monthly Unemployment Benefits				$			
Monthly Child Support/Alimony				$			
Monthly Rental Income				$			
Monthly Interest/Dividends				$			
Other Monthly Income:				$			
Please provide the following:	Total Gross Monthly Income			$			

Self Employed: **A copy of your latest tax return (business and individual) required**

Employed: **Copies of your last three (3) paycheck stubs are required**

Unemployed: **Gross monthly income prior to unemployment $ _____ Date unemployment began? ___/___/___**

Assets	YES	NO	BALANCE
Do you own stocks or bonds?			$
Do you have a checking account?			$
Do you have a savings account?			$
Do you have a money market account?			$
Do you own other property than current residence?	☐ Yes	☐ No	How many do you own? _____ Address below
Address _____	Address _____		
City, State and Zip Code _____	City, State and Zip Code _____		
Do you own a car(s)? ☐ Yes ☐ No How Many? _____			
Year _____ Make/Model _____	Year _____ Make/Model _____		

Monthly Expenses	Monthly Payment	Balance Owed
Rent/Mortgage (including taxes & insurance)	$	$
Utilities (electric, phone, water, sewer, cable)	$	$
Food/Groceries	$	$
Auto Loan(s)	$	$
Credit Card (s) Company Name		
	$	$
	$	$
	$	$
	$	$
Medical Bills Physician/Provider Name		
	$	$
	$	$
Auto Fuel	$	$
Auto Insurance	$	$
Health Insurance	$	$
Medications	$	$
Other Monthly Expenses	$	$
	$	$

Additionally, I understand that in accordance with Florida Statue 817.50 providing false information to defraud a hospital for purposes to obtaining goods or services, is a misdemeanor in the second degree. I agree to repay the NCH Healthcare System for any assistance received or any recovery of funds from either another payor or through subrogation rights.

X _____ _____

Patient Signature **(if minor,** the responsibility party and relationship) Date

X _____ _____

Guarantor Signature (**Required)** Date

X _____ _____

Witness Signature **(Required)** Date

ATTENTION: PLEASE READ BEFORE COMPLETING THIS FORM

To better assist you with your account(s), please complete all sections of the enclosed document correctly, as we cannot grant you assistance without accurate and complete information. The fully completed forms must be received *within 10 days* of receipt. Failure to comply may result in further collection efforts.

*** On the back of the form there are 3 required signatures. This form cannot be processed without the required signatures.

The Patient:	The person who received the service (parent or legal guardian if a minor)
The Guarantor:	The person financially responsible for the bills
Witness:	A person who sees you sign the form. This signature is only to verify that you are the person who has signed the form. The witness is not verifying that any of the information is true or correct.

*** Spouse or Parent: Please check spouse or parent on the front page

*** Requested income documentation (copies only; originals will not be returned to you). For example, paycheck stubs, personal tax forms (business tax forms if applicable) and W-2 forms.

*** The income information requested is Gross not Net.

*** If no income, explain how your expenses are paid and by whom.

*** If unemployed, explain if you receive unemployment benefits and the amount.

*** If unemployed, write the date you became unemployed and your income prior.

*** Please complete both sides of the form.

If you have any questions regarding the completion of this form, please contact our customer service department at (239) 624-6400 or (800) 436-8454.

Thank you for your cooperation

See reverse side for Spanish
Para Español vea el lado contrario

Revised 09/15/09