

# PERSONAL FINANCIAL DISCLOSURE



<p><b>Patient Information:</b></p> <p>Patient's Name: _____  <small style="margin-left: 100px;">Last,</small> <small style="margin-left: 150px;">First</small> <small style="margin-left: 100px;">Middle</small></p> <p>Address: Number _____ City _____ State _____ Zipcode _____</p> <p>Phone: Home: (____) _____</p> <p>Mobile: (____) _____</p>	<p><b>Patient's Information:</b></p> <p>Date of Birth: _____</p> <p>Employment Status          Employed: Part time    Full time          Not Employed          Student</p> <p>Marital Status: __ Married __ Single __ Other</p> <p>Number of Claimed Dependents: _____  <small>(As claimed on Business or Personal Income Taxes)</small></p> <p><b>Spouse Information:</b></p> <p>Spouse's Name: _____</p> <p>Employer: _____</p> <p>Work Phone #: _____</p>
---	--

**Income Information:**

Gross Household Income: \_\_\_\_\_

Patient's Net Monthly Income: \_\_\_\_\_

Spouse's Net Monthly Income: \_\_\_\_\_

Other Income Miscellaneous: \_\_\_\_\_

Source of Other Income: \_\_\_\_\_

**Please Furnish Copies of Last Year's Income Tax Returns & Last Month's Pay Stubs for All Earnings**

**Expenses (Monthly Amounts):**

Rent/Mortgage: _____	Child Support/Care/Tuition: _____
Groceries: _____	Gas/Transportation Expense: _____
Utilities: _____	Health Ins. Premiums & Expenses: _____
Phone: _____	Life/Disability Insurance Premiums: _____
Cable/DSL: _____	Home Insurance & Main. Fees: _____
Auto Payments: _____	Credit Card Debit: _____
Auto Insurance: _____	Miscellaneous Expenses: _____

Total Income: \_\_\_\_\_ ( - ) Total Expenses: \_\_\_\_\_ ( = ) Disposable Income: \_\_\_\_\_

**Please Make Certain all Income and Expenses Are Listed on This Forms (Use Back, if Necessary)**

**Attestation of Accuracy & Truthfulness:**

I the undersigned certify that the above information is true and accurate to the best of my knowledge. \_\_\_\_\_  
Initials

I understand the information submitted is subject to verification. \_\_\_\_\_  
Initials

I understand that financial assistance is determined by the ExercisAbilities staff using the above information.  
 I also understand completion of this form does not guarantee financial assistance \_\_\_\_\_  
Initials

---

Signature \_\_\_\_\_ Date \_\_\_\_\_

Approved % of sliding scale fee to apply \_\_\_\_\_ %

---

Business Office Manager Recommending \_\_\_\_\_ Executive Director Approval \_\_\_\_\_