Duke University Health System
Financial Hardship Form

A. - FAMILY INFORMATION	Patient / Guarantor # 1	Spouse / Guarantor # 2
1. First name, middle initial (please print)		
Last name (please print)		
2. Street address:		
3. City, state, zip code		
4. Social security number		
5. Day phone (area code)		
6. Evening phone (area code)		
7. Employed	YES NO SELF	YES NO SELF
8. Name of employer/company		
9. Employer/company street address:		
10. City, state, zip code		
11. How long have you worked here?	_____ Years ____ Months	_____ Years ____ Months
12. Number of dependents	_____	_____

B. - FINANCIAL DATA	Patient / Guarantor # 1	Spouse / Guarantor # 2
MONTHLY INCOME		
1. Gross salaries, wages before taxes		
2. Business Income		
3. Rental Income		
4. Investment Income		
5. Income from Estates/Trusts		
6. Alimony Income		
7. Child Support		
8. Social Security		
9. Aid to Dependant Children		
10. Public Assistance Income		
11. Other Income (list amount & source) (lines 11-12)		
12.		
13. Total Income All Sources		

C. - FINANCIAL DATA		
ASSETS		
1. Cash on hand		
2. Checking Account(s) balance		
3. Savings Account(s) balance		
4. Mutual Funds current value		
5. Stocks current value		
6. Bond(s) current value		
7. Home - assessed value		
8. Rental property assessed value		
9. Business property assessed value		
10. Automobile(s) -estimated value		
List make,model & year below:		
Auto # 1.		
Auto # 2.		
11. Recreational Vehicle(s) estimated value		
12. Boat(s) estimated value		

Duke University Health System
Financial Hardship Form

	Patient / Guarantor # 1	Spouse / Guarantor # 2
13. Cash value of life insurance		
14. Cash value of pension		
15. Total Assets		

Comments:

Required Documentation: (include copies for yourself and spouse/guarantor)

(1) Attach copies of your most recent tax return, including W-2 forms and supporting schedules.
(2) Last 2 pay stubs
(3) written verification of any other income received (e.g. child support, social security, alimony).
OR
(1) A letter from an employer verifying income (include employer's phone number and address).
(2) A letter from you stating your source for paying living expenses if you have no income.

Mail documentation to:

PRMO Self Pay
5213 South Alston Ave
Durham, N.C. 27713

I hereby acknowledge that the above information is true and accurate to the best of my knowledge.

I further grant the Health System authorization to verify any or all information given, and also authorize a consumer credit report if necessary.

Patient/Guarantor # 1 -Signature **Date**

Spouse/Guarantor # 2- Signature **Date**

FOR OFFICE USE ONLY

ACCOUNT INFORMATION

Entity (PDC, DRH, RCH, DUH): _____
Account/Invoice Number (s): _____
Balance Due: _____
Date(s) of Service: _____

CHARITY DETERMINATION

Approved_____ Denied_____ By_____ Date_____