Kansas City Orthopaedic Institute

Statement of Financial Position

Part A - PATIENT INFORMATION

Patient's Full Name | Social Security Number

Address (Number and Street, City, State Zip Code | Phone Number ( )

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Name and Address of Employer | Phone Number of Employer ( )

Occupation | Length of Employment | Gross Monthly Salary

If not presently employed, name and address of last Employer | Occupation

Patient's Bank (Name and Branch Address) | Checking: Balance $_____ | Savings: Balance $_____

Part B - Responsible Party Information (Spouse, Parent, Guardian, etc.) If patient, go to Part C

Full Name of Person Responsible for the Bill | Relationship to Patient

Address (Number and Street, City, State Zip Code | Phone Number ( )

Name and Address of Employer | Phone Number of Employer ( )

Occupation | Length of Employment | Gross Monthly Salary

If not presently employed, name and address of last Employer | Occupation

Responsible Party's Bank (Name and Branch Address) | Checking: Balance $_____ | Savings: Balance $_____

Part C - Patient and Responsible Party's Assets

Housing Information ☐ Own ☐ Rent

☐ If Owned, value of house/land	Value $_____	Loan Balance $_____
☐ Other Property	Value $_____	Loan Balance $_____
☐ Stocks/Bonds	Value $_____	
☐ Certificates of Deposit	Value $_____	
☐ IRAs	Value $_____	
☐ Other	Value $_____	

Part D - (For Information Only) RESIDENCY IS NOT A REQUIREMENT FOR FINANCIAL ASSISTANCE

Have you been a resident of the Kansas City area for the preceding 3 years?

☐ Yes ☐ No

Part E - Dependents

Dependents (not including self) claimed on your latest tax return.

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Part F - Income & Expenses

Total Family Income PER MONTH		Total Family Expenses PER MONTH	
$_____	Patient/Responsible Party Salary (Gross)	$_____	House Payment/Rent
$_____	Parent/Spouse's Salary (Gross)	$_____	Monthly Utilities/Phone
$_____	Social Security Benefits	$_____	Monthly Insurance Premiums
$_____	Pension	$_____	Car Payments
$_____	Disability Benefits	$_____	Cable or Direct TV
$_____	State Benefits	$_____	Internet Services
$_____	Food Stamps	$_____	Food
$_____	Alimony/Child Support	$_____	Monthly Medical Payments
$_____	Rental Income		List in detail in Part G
$_____	Business Income	$_____	Charge Account Payments
$_____	Other	$_____	Loan Payments
			List in detail in Part G
		$_____	Child Care
		$_____	Child Support
		$_____	Other (Describe)
$_____	TOTAL MONTHLY INCOME	$_____	TOTAL MONTHLY EXPENSES

Part G - Financial Obligations

Financial Obligations (medical, charge accounts, loans, etc.)

Name	Address	Balance Owed	Monthly Payment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Part H - Special Situations

Special situations not previously listed affecting your financial status.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Part I - Attach Copies of the Following Information

1. Prior Year Income Tax Return forms (signed). Must be complete tax return, including all schedules.
2. Bank statements for the last two months.

By my signature below, I certify that the above information is an accurate and complete statement of my current financial position and give my permission to verify this information.

Signature of Patient/Responsible Party _____ Date _____