EXHIBIT 2-CT (Connecticut Hospitals)
PATIENT/PAYMENT SOURCE FINANCIAL WORKSHEET

Patient Name: _____ Account Number: _____
Household Size: _____

1A Calculation of Available Income

Monthly Salary/Pension	**_____ x 12 _____**	
Monthly SSI/VA	**_____ x 12 _____**	
Income Total	**_____ x 12 _____**	**(AA)**

1B Calculation of Monthly Expenses

Rent	**_____**	
Electric	**_____**	
Gas	**_____**	
Telephone	**_____**	
Water	**_____**	
Car Payments	**_____**	
Credit Cards	**_____**	
Insurance	**_____**	
Other _____	**_____**	
Food ($100.00 x dependents)	**_____**	
Monthly Expense Total	**_____**	
Expense Total	**_____x 12_____**	**(BB)**

1C Eligible Income for Hospital Bills **_____ (CC)**
(AA – BB) (If less than 0, enter 1)

1D Estimate Hospital Billing to Patient **_____ (DD)**

1E Identification of Liquid Assets

Bank Accounts	**_____**	
Bonds	**_____**	
Stocks	**_____**	
CD's	**_____**	
Mutual Funds	**_____**	
Liquid Asset Total		**_____ (EE)**

1F Total Patient Due minus Liquid Assets (DD- EE) **_____ (FF)**

1G Eligible Income minus Patient due (CC-FF) **_____ (GG)**

Note: If GG is a negative number, then patient will have no financial responsibility.

_____ I attest that the above information is correct.

_____ I attest that the Patient/Payment Source is unemployed and cannot provide employment documentation.

_____ _____

Signature of Patient/Payment Source **Date**

EXHIBIT 2-NY (New York Hospitals)

PATIENT/PAYMENT SOURCE FINANCIAL WORKSHEET

Patient Name: _____ Account Number: _____

Household Size: _____

1A Calculation of Available Income

Monthly Salary/Pension	**_____ x 12 _____**
Monthly SSI/VA	**_____ x 12 _____**
Income Total	**_____ x 12 _____ (AA)**

1B Calculation of Monthly Expenses

Rent	**_____**
Electric	**_____**
Gas	**_____**
Telephone	**_____**
Water	**_____**
Car Payments	**_____**
Credit Cards	**_____**
Insurance	**_____**
Other _____	**_____**
Food ($100.00 x dependents)	**_____**
Monthly Expense Total	**_____**
Expense Total	**_____x 12_____ (BB)**

1C Eligible Income for Hospital Bills **_____ (CC)**
(AA – BB) (If less than 0, enter 1)

1D Estimate Hospital Billing to Patient **_____ (DD)**

1E Eligible Income minus Patient due (CC-DD) **_____ (EE)**
Note: If EE is a negative number, then patient will have no financial responsibility.

_____ I attest that the above information is correct.

_____ I attest that the Patient/Payment Source is unemployed and cannot provide employment documentation.

_____ _____

Signature of Patient/Payment Source **Date**