LifeStream
Where Hope Comes to Life

FINANCIAL STATEMENT

Consumer: _____ Phone: _____

Street Address: _____ City: _____

Mailing Address: _____ City/Zip: _____

LifeStream Behavioral Center is a Private, Non-Profit Organization which receives some State funding to supplement operating expenses. However, only a portion of our budget is covered by these funds, therefore, we are dependent on consumer fees. The consumer is responsible for the full amount of the hospital bill. If you are indigent or on a limited income, we may be able to work with you to defer payment on a payment schedule or make an adjustment on your hospital bill according to the Federal Poverty Guidelines.

List all household members who are financially dependent upon you (including you and your spouse). Do not list anyone who is over 18 years of age **UNLESS** they are financially dependent on you or they are disabled.

NAME	AGE	RELATIONSHIP	PLACE OF EMPLOYMENT	INCOME

Do you have? ☐Insurance ☐Medicare ☐Medicaid/Medipass **Number of Dependents:** ____

Financial Statements Due (Include Worker's Comp. Civil Actions, Etc.): _____

_____

Other Income:
☐ AFDC $_____ ☐ Disability $_____
☐ Child Support $_____ ☐ Soc. Sec. $_____
☐ Food Stamps $_____ ☐ Charity $_____
☐ Savings $_____ ☐ Checking $_____

Does Family Own:
☐ Home ☐ Mobile Home Monthly Payment: $_____ Paid: ☐Yes ☐No
☐ Property Value: $_____ Monthly Payment: $_____ Paid: ☐Yes ☐No
☐ Car Value: $_____ Monthly Payment: $_____ Paid: ☐Yes ☐No
☐ Truck Value: $_____ Monthly Payment: $_____ Paid: ☐Yes ☐No

Is car or truck essential in earning a living? ☐ Yes ☐ No

List all your Debts (include mortgage/rent, phone, utilities, credit cards, insurance, food, etc.):

COMPANY TO WHOM DEBT IS OWED	PAYMENT DUE DATE	AMOUNT PAID	DATE OF LAST PYMT.

TOTAL MONTHLY INCOME: $_____ **TOTAL MONTHLY EXPENSES:** $_____

I hereby certify that the above statements are true to the best of my knowledge and belief, and I accept responsibility for the cost of medical treatment, and/or the cost of hospitalization that is recommended. Additionally, I understand that in accordance with Florida Statutes 817.50, providing false information to defraud a hospital for the purpose of obtaining goods or services, is a misdemeanor in the second degree.

_____ _____
Signature of Consumer, Consumer's Guardian or Responsible Party Date

_____ _____
Witness Date

FISCAL:003:R:03/10

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