Providence Hospital

Post Office Box 851537

Mobile, AL 36685

(251) 633-1500

FINANCIAL STATEMENT

PATIENT INFORMATION

Name				Social Security Number	
Date of Birth	Sex	Marital Status	Home Phone Number		
Street Address		City	State	Zip	
Employer		Employer Contact		Employer Phone Number	
Spouse's Name				Social Security Number	
Date of Birth	Spouse's Employer			Contact / Phone Number	

RESPONSIBLE PARTY INFORMATION (if other than patient or spouse)

Name				Social Security Number	
Date of Birth	Sex	Marital Status	Relationship to Patient		
Street Address		City	State	Zip	
Employer		Employer Contact		Employer Phone Number	

DEPENDENTS (Excluding Patient & Spouse)

Name	Age	Relationship	Social Security Number
Name	Age	Relationship	Social Security Number
Name	Age	Relationship	Social Security Number
Name	Age	Relationship	Social Security Number

ASSISTANCE

Have you applied for assistance? (Circle one) YES NO	If yes, Agency Name	Date Applied

GROUP INSURANCE INFORMATION (MUST BE ANSWERED)

Does your employer provide group medical insurance? YES NO

If YES, what are monthly premiums? Individual: $ _____

Family: $ _____

If you have not enrolled, please provide explanation: _____

~ BUSINESS OFFICE USE ONLY ~

Recommendation:

FINANCIAL STATEMENT

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INCOME (per month)		EXPENSES (per month)	
Household Wages $	Social Security Income $	Mortgage $	Rent $
V.A. Pension $	Unemployment $	Electricity $	Gas $
Worker's Compensation $	Child Support $	Water $	Primary Telephone $
Alimony $	Rental Income $	Groceries (less Food Stamps) $	Food Stamps YES NO $
Retirement $	Other Income $	Day Care $	Alimony/Child Support $
Savings Account Bal $	CD's $	Medical Insurance $	Student Loans $
Checking Account Bal $	Annuity $	Homeowners Insurance (if not included in mortgage payment) $	
Other $	Other $		
		Vehicle 1 $	Vehicle 2 $
		Medical Expenses: Provider:	Balance: $
		Medical Expenses: Provider:	Balance: $
	Business Office Use Only	Pharmacy Expenses: Provider:	Balance: $
		LIFE INSURANCE:	
		Policy Value: $	Monthly Premium: $
Total Income: $		**Total Expenses:** $	

PROPERTY / ASSETS

Real Estate: Value $_____

Primary Residence (description of property):

Other Assets ******MUST BE ANSWERED***** (i.e. Coin, stamp, art, antique collections…)

Value $_____

Description:

VEHICLE

Year	Make	Model
Year	Make	Model

In addition to the information requested above, I have provided the following as evidence of my income: (1) My last three bank statements; (2) IRS Form 1040 with Schedules and W-2 Statements. If I am unable to provide this information, Providence Hospital has my permission to request the information from my employer and any other sources. To the best of my knowledge, I hereby certify that the above information is true and correct, and that this is a complete record of my assets and liabilities. Providence Hospital has my permission to investigate my credit history.

Date	Signature of Patient or Responsible Party
Date	Signature of Spouse
Date	Signature of Interviewer (if applicable)