

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)			If yes, Agency Name		Date Applied	
YES NO						
~ BUSINESS OFFICE USE ONLY ~						
Recommendation:						

FINANCIAL STATEMENT

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INCOME (per month)		EXPENSES (per month)	
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 \$	Dental Insurance \$
Checking Account Bal \$	Annuity \$	Homeowners Insurance (if not included in mortgage payment) \$	
Other \$	Other \$	Student Loans \$	Business Office Use Only \$
		Vehicle 1 \$	Vehicle 2 \$
		Medical Expenses: Provider: Balance: \$	
		Medical Expenses: Provider: Balance: \$	
		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)		Value	\$
Description:			
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)