

STATEMENT OF FINANCIAL CONDITION

PATIENT NAME _____ ADDRESS _____ ACCOUNT # _____	SPOUSE _____ PHONE _____ SSN _____ <div style="display: flex; justify-content: space-between; width: 100%;"> (PATIENT) (SPOUSE) </div>
---	--

FAMILY STATUS: List all dependents that you support

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

EMPLOYMENT AND OCCUPATION

Employer: _____ Position: _____
 Contact Person & Telephone: _____
 If Self-Employed, Name of Business: _____

Spouse Employer: _____ Position: _____
 Contact Person & Telephone: _____
 If Self-Employed, Name of Business: _____

CURRENT MONTHLY INCOME

	Patient	Spouse
<i>Add:</i> Gross Pay (before deductions)	_____	_____
<i>Add:</i> Income from Operating Business (if Self-Employed)	_____	_____
<i>Add:</i> Other Income:		
Interest and Dividends	_____	_____
From Real Estate or Personal Property	_____	_____
Social Security	_____	_____
Other (specify):	_____	_____
Alimony or Support Payments Received	_____	_____
<i>Subtract:</i> Alimony, Support Payments Paid	_____	_____
<i>Equals:</i> Current Monthly Income	_____	_____
Total Current Monthly Income (add Patient+Spouse Income from above)	_____	_____

FAMILY SIZE

Total Family Members _____
 (add patient, spouse and dependents from above)

By signing this form, I agree to allow Sutter Health to check employment and credit history for the purpose of determining my eligibility for a financial discount. I understand that I may be required to provide proof of the information I am providing.

 (Signature of Patient or Guarantor) (Date)

 (Signature of Spouse) (Date)