

STATEMENT OF FINANCIAL CONDITION

PATIENT NAME _____ SPOUSE _____
 ADDRESS _____ PHONE _____
 ACCOUNT # _____ SSN _____
 (PATIENT) (SPOUSE)

FAMILY STATUS: List all dependents that you support.

| Name | Age | Relationship |
|-------|-------|--------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

EMPLOYMENT AND OCCUPATION

Employer: _____ Position: _____
 Contact person and telephone: _____
 If self-employed, Name of Business: _____
 Spouse Employer: _____ Position: _____
 Contact person and telephone: _____
 If self-employed, Name of Business: _____

CURRENT MONTHLY INCOME

| | Patient | Spouse |
|--|---------|--------|
| Gross Pay (before deductions) | _____ | _____ |
| Add: Income from Operating Business (if Self-Employed) | _____ | _____ |
| Add: Other Income | | |
| Interest and Dividends | _____ | _____ |
| From Real Estate or Personal Property | _____ | _____ |
| Social Security | _____ | _____ |
| Other (specify): _____ | _____ | _____ |
| Alimony or Support Payments Received | _____ | _____ |
| Subtract: Alimony, Support Payments Paid | _____ | _____ |
| Equals: 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)

Mail completed form and attachments to:
 Sutter Gould Medical Foundation
 1001 Sutter Street, Suite 1000, San Francisco, CA 94109
 For fax to: (415) 774-1111