STATEMENT OF FINANCIAL CONDITION

PATIENT NAME _____ **SPOUSE** _____
ADDRESS _____ **PHONE** _____
ACCOUNT # _____ **SSN** _____

FAMILY STATUS: List all dependents that you support.

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

FAMILY SIZE:
Total Family Members
(add patient, spouse and dependents above) _____

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

CURRENT MONTHLY INCOME

		Patient	Spouse
	Gross Pay (before deductions)	_____	_____
Add:	Income from Operating Business (if Self-Employed) **(Must supply proof of income – W2 or pay stub)**	_____	_____
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	_____	

MONETARY ASSETS _____
(Exclude Pension and Deferred Compensation)

Financial Institution	_____	_____
Financial Institution	_____	_____
Total Monetary Assets		_____
Less $10,000		-10,000
Remainder		_____
Less 50%		_____

Discretionary Monetary Assets _____

By signing this form, I agree to allow Hi-Desert Memorial Health Care District to check employment and credit history for the purpose of determining my eligibility for 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)