STATEMENT OF FINANCIAL CONDITION (Attachment A)

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

FAMILY STATUS: List all dependents that you support **mm/dd/yy**

Name	Age	Relationship	DOB

EMPLOYMENT AND OCCUPATION

Employer:	None	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
	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 Delano Regional Medical Center to check employment and credit history for the purpose of determining my eligibility afor 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)