- ☐ PROVIDENCE PORTLAND MEDICAL CENTER
- ☐ PROVIDENCE MILWAUKIE HOSPITAL
- ☐ PHS CLINIC
- ☐ PROVIDENCE ST. VINCENT HOSPITAL
- ☐ PROVIDENCE SEASIDE HOSPITAL
- ☐ PROVIDENCE MEDFORD MEDICAL CENTER

RETURN TO : ____________________

Please answer the questions below as completely as possible. All information will be kept confidential. If you have any questions, please call (503) 215-4300, (541) 732-5077 or (877) 215-7833 outside Portland, Monday - Friday 8:00 a.m. to 8:30 p.m.

PATIENT'S NAME LAST	FIRST	M.I.	SOCIAL SECURITY NUMBER

PATIENT'S DATE OF BIRTH	U.S. CITIZEN ☐ YES ☐ NO	NAME OF PERSON RESPONSIBLE FOR PAYING THE BILL	RELATIONSHIP

The following information should be about the person responsible for paying the bill.

ADDRESS STREET	CITY	STATE	ZIP	SOCIAL SECURITY NUMBER

TELEPHONE NUMBER HOME	WORK

DATE OF BIRTH	NO. OF PEOPLE IN HOUSEHOLD	AGES OF CHILDREN IN HOUSEHOLD

NAMES OF PEOPLE EMPLOYED, FULL-TIME OR PART-TIME, IN HOUSEHOLD / RELATIONSHIP

PERSON 1 ____________________

PERSON 2 ____________________

PERSON 3 ____________________

HEALTH INSURANCE COVERAGE (CHECK ALL THAT APPLY FOR YOUR HOUSEHOLD)

- ☐ MEDICARE; IDENTIFICATION NUMBER: ____________________
- ☐ MEDICAID; STATE IDENTIFICATION NUMBER: ____________________
- ☐ PRIVATE INSURANCE; NAME OF COMPANY: ____________________ GROUP NUMBER: __________ I.D. NO.: __________
- ☐ OTHER: ____________________ I.D. NO. ____________________

HOUSEHOLD INCOME Please provide the following information for each person, if applicable:

	PERSON 1	PERSON 2	PERSON 3
MONTHLY WAGES / SALARY (BEFORE TAX INCOME)	$	$	$
UNEMPLOYMENT	$	$	$
SOCIAL SECURITY, PENSIONS	$	$	$
ALIMONY / CHILD SUPPORT	$	$	$
OTHER (Stocks, Bonds, IRA's, etc.)	$	$	$

Please list any other unpaid hospital or doctor bills.

HOSPITAL / DOCTOR OWED	CURRENT BALANCE	MONTHLY PAYMENT
	SUBTOTAL	

FOR BUSINESS OFFICE USE ONLY TRAN CODE __________ ☐ TRADITIONAL MEDICARE

☐ APPROVED ASSISTANCE __________ PERCENT(%) CORPORATE # __________ BALANCE __________

SEND NOTICE OF DETERMINATION: ☐ YES ☐ NO ACCOUNT # __________ BALANCE __________

ACCOUNT # __________ BALANCE __________

APPROVED BY: __________ ACCOUNT # __________ BALANCE __________

CONTINUE ON BACK SIDE OF SHEET

EXPENSES

Please list all household credit cards or other commercial accounts (e.g. VISA, Mastercard, American Express, department store accounts, student loans, etc.)

NAME OF CREDITOR	CURRENT BALANCE	MONTHLY PAYMENT
	SUBTOTAL	

Please list all other monthly household living expenses.

	MONTHLY PAYMENT		MONTHLY PAYMENT
MORTGAGE PAYMENT		GASOLINE OR OTHER TRANSPORTATION	
Tax Value		CHILD CARE	
Mortgage Balance			
RENT		INSURANCE (Home, Car, Health, Life)	
CAR PAYMENT(S)		TAXES	
Make(s) / Model(s)		MEDICATIONS	
Year(s)			
FOOD		OTHER:	
UTILITIES		OTHER:	

Does your household have checking account(s)? ☐ YES ☐ NO If Yes, Balance: ______

Does your household have savings account(s)? ☐ YES ☐ NO If Yes, Balance: ______

Have you ever filed bankruptcy? ☐ YES ☐ NO If Yes, When: ______

Please make additional comments about your household's financial circumstances that may affect your ability to pay the hospital bill:

Please check that you have provided: ☐ Previous year's tax returns ☐ Income verification showing year to date earnings or paystubs for the last 3 months.

I hereby certify the information contained in the above financial questionnaire is correct and complete to the best of my knowledge. I understand that Providence may verify the above information.

X ______
RESPONSIBLE PERSON'S SIGNATURE

DATE