SPARTANBURG
Regional Healthcare System

☐ SMC ☐ SHRC ☐ PMC

Provider Statement
Account #:_____

Please fill out this form if the patient has zero income and you are helping pay their monthly expenses.

I _____, _____,
(Provider's Name) (Relationship to Patient)

Provide _____
(Patient's Name)

With the following estimated dollar amount per month (if no dollar amount given, application will be denied):

Housing: $_____ monthly

Food: $_____ monthly

Personal Expenses: $_____ monthly

Other: $_____ monthly

TOTAL: $_____ monthly

Do you claim the patient on your tax return? ☐ Yes ☐ No

If yes, please send a copy of provider's signed tax return for the current year. Please include all pages of your tax return.

If no, please include the first page (form 1040A) of the provider's tax return to show that patient is not being claimed.

By filling out this form, you, the patient's provider, state that you are helping the patient either by allowing the patient to live in your home at no cost or providing help with the cost of living for the patient listed above. This in no way makes you responsible for the patient's hospital bill.

_____ _____
Provider's Signature Patient's Signature

_____ _____ _____ _____
Date Time Date Time

Patient Label