SPARTANBURG
Regional Healthcare System

Provider Statement

Patient Name:	Account Number:

This is a statement explaining monthly support from you with dollar amounts of the care that is provided to the patient. This includes room and board, personal expenses, etc.

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.

If you have questions or need help completing this form, call Spartanburg Regional Healthcare System Patient Financial Services at: 864-596-1001 or 800-281-5346.

Provider's Name	Relationship to Patient	Contact Number

I provide the patient indicated above with the following estimated dollar amount per month (if no dollar amount given, application will be denied):

Expense	Monthly Amount	Comment (if applicable)
Housing		
Food		
Personal Expenses		
Other		
Total		

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

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

If no, please include the first page (form 1040A) of your tax return to show you are not claiming the patient.

_____ _____

Provider's Signature Patient's Signature

_____ _____ _____ _____

Date Time Date Time