

## Cleveland Clinic EXCEPTIONAL CIRCUMSTANCE FORM

## **Patient Information**

First Name  Last Name  Date of Birth Relationship	Name		Account number						
Household Income  1. Household Member (Spouse & Natural or Adopted Children under 18 years old)  First Name  Last Name  Date of Birth Relationship  A control of the control of Birth Relationship  Control of Birth Rela	Address								
First Name  Last Name  Date of Birth Relationship  Relationship  Relationship  Relationship  Date of Birth Relationship  Relationship  Relationship  Relationship  Relationship  Relationship	Household			Annual Household Income					
2. I am unable to pay my Cleveland Clinic medical bill due to the following circumstances  3. Total monthly Expenses, including Prescription cost and other medical bills:  4. Is there any information you would like to provide?	1. Household Member (Spouse & Natural or Adopted Children under 18 years old)								
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Caregiver receiving request Date:	4. Is there any information you would like to provide?								
Caregiver receiving request Date:									
	Caregive	er receiving request				Date:			



## **Monthly Household Expenses**

Patient Name:				
Type of Expenses	Monthly Payment	Balance Owed		
Mortgage or Rent				
Water				
Electric				
Phone				
Cable				
Car Payment				
Car Insurance				
Credit Cards				
Personal Loans				
Hospital & Doctor				
Miscellaneous				
Food				
SUB TOTAL				