Wallowa Memorial Hospital
Application for Patient Financial Assistance

In accord with our Mission Statement and as a community healthcare organization, Wallowa Memorial Hospital offers a program of patient financial assistance to qualified patients. In order to determine your potential qualification, please complete these two pages and supply the documentation that is requested. Proof of income must be included with this financial statement. Proof of income includes your latest filed income tax return and copies of recent payroll stubs. In addition, please include copies of your last three bank statements. All information relating to the application for Patient Assistance will be kept confidential.

Financial Statement

Head of Household:_____
Address:_____
City:_____State_____Zip_____
Telephone (____) _____
Occupation/Employer_____
Spouse Name:_____
Occupation/Employer_____

Name of Members Residing in Household not listed above:

Name	Relationship	Birthdate

Income: Please list all income

	For 1 Month	**For Last 3 Months**
Wages, Farm Inc, Self-employment		
Public Assistance Food Stamps, Housing		
Social Security, SSI		
Unemployment Comp Worker Comp		
Alimony, Child Support		
Pensions, Dividends, Interest, etc		
Native American Monies		
Other, please explain		
Total Income	**$**	**$**

Assets (I Own)	**Liabilities (I owe)**
Cash on Hand	Mortgage
Savings/CD's	Bank Loans
Checking	Auto/RV loan
Auto/RV	Charge Cards
Home	
Other	
Other	
Other	Medical Bills
	Other
	Total Liabilities $
Total Assets $	Total Monthly Payments $

MONTHLY EXPENSES	
Rent	Food
Utilities	Heating Fuel
Auto Expenses	Insurance
Other	Other
Other	Other
Total Monthly Expenses $	

Please Read Carefully

I understand that the information I submit concerning my annual income, net assets and number of residents in my household is subject to verification by Wallowa Memorial Hospital. I authorize a representative of the hospital to verify the information submitted.

_____ _____

Signature **Date**