



Financial Assistance/Indigent Application Form – confidential

SCREENING INFORMATION

| |
|---|
| Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, list preferred language:</i> |
| Has the patient applied for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the patient receive state public services such as TANF, Basic Food, or WIC? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is the patient currently homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is the patient's medical care need related to a car accident or work injury? <input type="checkbox"/> Yes <input type="checkbox"/> No |

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 21 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION

| | | |
|---|-------------------------|---|
| Patient first name | Patient middle name | Patient last name |
| <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (may specify _____) | Birth Date | Patient Social Security Number (optional) |
| Person Responsible for Paying Bill | Relationship to Patient | Birth Date |
| Mailing Address _____ _____ | | Social Security Number (optional) |
| City | State | Zip Code |
| Employment status of person responsible for paying bill <input type="checkbox"/> Employed (date of hire: _____) <input type="checkbox"/> Unemployed (how long unemployed: _____) <input type="checkbox"/> Self-Employed <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Other (_____) | | Main contact number(s) _____ _____ Email Address: _____ |

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

FAMILY SIZE _____ *Attach additional page if needed*

| Name | Date of Birth | Relationship to Patient | If 18 years old or older: Employer(s) name or source of income | If 18 years old or older: Total gross monthly income (before taxes): | Also applying for financial assistance? |
|------|---------------|-------------------------|---|---|--|
| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

All adult family members' income must be disclosed. Sources of income include, for example:

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (*please explain* _____)

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INCOME INFORMATION

REMEMBER: You must include proof of income with your application.

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose and provide proof for every identified source of income.

Proof of income includes the following:

- Last year's income tax return, W-2 forms, and schedules;
- Bank account statements: personal and business (*most recent 3 months*);
- Current pay stubs (*most recent 3 months*).

If applicable:

- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance;
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

EXPENSE INFORMATION

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

| | | | |
|---------------------|--|------------------|----------|
| Rent/mortgage | \$ _____ | Medical expenses | \$ _____ |
| Insurance Premiums | \$ _____ | Utilities | \$ _____ |
| Other Debt/Expenses | \$ _____ (<i>child support, loans, medications, other</i>) | | |

ASSET INFORMATION

(This section is optional and may be used to determine eligibility for other assistance programs)

| | |
|--|---|
| Current checking account balance \$ _____ | Does your family have these other assets? Please check all that apply <input type="checkbox"/> Stocks <input type="checkbox"/> Bonds <input type="checkbox"/> 401K <input type="checkbox"/> Health Savings Account(s) <input type="checkbox"/> Trust(s) <input type="checkbox"/> Property (excluding primary residence) <input type="checkbox"/> Own a business |
| Current savings account balance \$ _____ | |

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that *Wallowa Memorial Hospital* may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

Signature of Person Applying

Date
