

**WASHINGTON COUNTY HOSPITAL**  
**REQUEST FOR FINANCIAL ASSISTANCE**

Name \_\_\_\_\_ Account Number \_\_\_\_\_

Address \_\_\_\_\_ Date of Service \_\_\_\_\_

City, State \_\_\_\_\_

Zip Code \_\_\_\_\_ Phone # \_\_\_\_\_

**Please list income for the last 3 months.**

Wages (attach copies of check stubs) \$ \_\_\_\_\_

Self Employment income (attach proof) \$ \_\_\_\_\_

Public Assistance \$ \_\_\_\_\_

Social Security \$ \_\_\_\_\_

Unemployment Comp \$ \_\_\_\_\_

Workman's Comp \$ \_\_\_\_\_

Pension Income \$ \_\_\_\_\_

Alimony/Child Support \$ \_\_\_\_\_

Dividend/Interest \$ \_\_\_\_\_

Other \$ \_\_\_\_\_

**List all family members still living at home and their date of birth:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Please list financial resources:**

CHECKING/SAVINGS ACCOUNTS \_\_\_\_\_ CDs \_\_\_\_\_

STOCKS, BONDS, IRA'S \_\_\_\_\_

LIFE INS. FACE VALUE \_\_\_\_\_ CASH VALUE \_\_\_\_\_

**REAL ESTATE OWNED BY YOU OR SPOUSE:**

MARKET VALUE \$ \_\_\_\_\_

LOAN VALUE \$ \_\_\_\_\_

TOTAL EQUITY \$ \_\_\_\_\_

**Please list any other assets not listed above** \_\_\_\_\_

WILL THE PATIENT BE UNABLE TO WORK OR GO TO SCHOOL DUE TO PHYSICAL IMPAIRMENT?

YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, WHAT IS THE DISABLING CONDITION OR DIAGNOSIS? \_\_\_\_\_

HOW LONG WILL THE PATIENT BE DISABLED? \_\_\_\_\_  
(Please attach a statement from the doctor)

MONTHLY EXPENSES: RENT/MORTGAGE \$ \_\_\_\_\_

CAR PAYMENTS \$ \_\_\_\_\_

CREDIT CARD PAYMENTS \$ \_\_\_\_\_

MONTHLY UTILITIES (CELL PHONE, ETC) \$ \_\_\_\_\_

FOOD, CLOTHING, ETC \$ \_\_\_\_\_

OTHER MONTHLY EXPENSES \$ \_\_\_\_\_

MEDICAL EXPENSES \$ \_\_\_\_\_

TOTAL EXPENSES MONTHLY \$ \_\_\_\_\_

Along with this form I will attach copies of my Federal and State Income tax returns for the previous year.

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, insurance, etc..) which may be available for payment of my hospital bill, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this application is made so that the hospital can judge my eligibility for financial assistance based on the established criteria on file in the hospital. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

If my financial situation changes I understand I must notify the hospital immediately.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (Person Making Request)

\*\*\*THIS APPLICATION MUST BE RETURNED WITHIN 30 DAYS\*\*\*