



Date: _____

Patient Acct rep. _____

Telephone: _____

Completion of this Financial Assistance Application will allow us to determine if Northwest Healthcare is able to consider reduced payments based on financial need. The completed form and documentation of yearly household income must be returned to us within ten days.

Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

Your signature authorizes Northwest Healthcare to verify information provided in this financial statement by obtaining a credit report and/or other financial information.

Account Number		Balance \$	
Name	SSN	Date of Birth	
Spouse or Significant Other	SSN	Date of Birth	
Address	City/State	Zip Code	
Home Telephone	Work Telephone	Cell or Message Telephone	
Employer	Position	Date of Employment	
Does your employer offer insurance?	Yes No	Spouse's employer?	Yes No
Spouse/Significant Other's Employer	Position	Date of Employment	
Spouse/Significant Other's Work Telephone	Name and Age of Dependents	Total Number in Household	

*** DOCUMENTATION OF INCOME IS REQUIRED & MUST BE INCLUDED**

Monthly Income:	yourself	spouse/significant other
Employment/Gross Wages		
Unemployment		
Bonuses/Tips		
Public Assistance		
Social Security/Pensions		
Worker's Compensation		
Alimony/Child Support		
Other Sources (describe)		
Total Monthly Income		

*** Your most recent tax return is the best source to document your income. Any attachments to returns of Schedules must be included. Other forms of proof of income may be acceptable...ask us! Failure to supply complete information will result in a delay in processing.**



Assets:		Monthly Expenses:	
Cash on Hand	\$	Rent or House Payment	\$
Checking Account Balance	\$	Utilities	\$
Savings Account Balance	\$	Telephone	\$
Stocks/Bonds/IRA/401K	\$	Cable	\$
Cash Value of Life Insurance	\$	Groceries	\$
Auto 1		Prescriptions	\$
Year/Make		Clothing	\$
Model		Childcare	\$
Value	\$	Child Support	\$
Loan Balance	\$	Vehicle Maintenance/Gasoline	\$
Auto 2		Monthly Payment (Auto 1)	\$
Year/Make		Monthly Payment (Auto 2)	\$
Model		Vehicle Insurance	\$
Value	\$	Health Insurance	\$
Loan Balance	\$	Life Insurance	\$
Current Home Value	\$	Other Loan payments	\$
Purchase Date		Payments on Credit Cards	\$
Purchase Price	\$		\$
Mortgage Loan Balance	\$	Payments on Medical Bills	\$
Other Property (Describe)	\$		\$
Recreational Merchandise	\$		\$
Other Assets (Describe)	\$	Other (Describe)	\$
Total Assets	\$	Total Monthly Expenses	\$

Estimated total of other outstanding medical bills: _____

- 1. In order for us to help you this completed form and documentation of your income is required and must be returned to us within 10 days.**
- 2. If you have any questions or are unable to provide complete information, let us know.**



Additional Information:

What is the amount of monthly payment you are able to make?

If you are not able to provide the information on this application or proof of your income, please explain.

If you have no income, please explain how you meet your daily expenses.

If your annual household income has increased or decreased from the past year to this current year, please explain.

Please provide any additional information about any other circumstances that you think will better help us to understand your situation.

Return by mail or in person to: **Information may also be faxed to:**

To contact your Patient Account Representative:

Signature _____

Your signature authorizes Northwest Healthcare to verify information provided in this financial statement by obtaining a credit report and/or other financial information.

Return this completed application and documentation of your income to us within 10 days. If you are unable to do so or if you have any questions about the required information, call us. Failure to comply and non-payment of balances will result in a negative effect on your credit. Past due accounts will accrue interest.