Central Washington Hospital
Financial Assistance Application

Patient Account Number(s): _____ Amount Due: _____

Name: _____ Date of Birth: _____

Spouse: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Marital Status: _____

DEPENDENTS THAT I SUPPORT:

Name	Age	Date of Birth	Relationship

INSURANCE:

Name of Insurance	Group Number	Policy Number

EMPLOYMENT:

Patient Employer: _____

Position Title: _____

Employer's Phone Number: _____ Length of Employment: _____

Rate of Pay: $_____ per (circle one) hour / week / month Hours worked per pay period: _____

Spouse's Employer: _____

Position Title: _____

Employer's Phone Number: _____ Length of Employment: _____

Rate of Pay: $_____ per (circle one) hour / week / month Hours worked per pay period: _____

OTHER INCOME:	Applicant	Spouse
☐ Social Security	$_____ mo.	$_____ mo.
☐ Veteran's	$_____ mo.	$_____ mo.
☐ Retirement	$_____ mo.	$_____ mo.
☐ Military Service Allotment	$_____ mo.	$_____ mo.
☐ Child Support	$_____ mo.	$_____ mo.
☐ Property Income/Tenants	$_____ mo.	$_____ mo.
☐ Unemployment Compensation	$_____ mo.	$_____ mo.
☐ Workman's Comp. (L & I)	$_____ mo.	$_____ mo.
☐ Union Benefits	$_____ mo.	$_____ mo.
☐ Insurance	$_____ mo.	$_____ mo.
☐ Friend/Relative	$_____ mo.	$_____ mo.

☐ Other _____ $_____ mo. $_____ mo.

ASSETS: Actual or Estimated Value

☐ Cash on hand, checking/savings accounts $_____
☐ Stocks, Bonds, Securities $_____
☐ Personal Property (Describe) _____ $_____
☐ Investment Real Estate Address _____ $_____
☐ Life Insurance: Company: _____ Policy # _____ $_____
☐ Auto: Make: _____ Year: _____ $_____
☐ Auto: Make: _____ Year: _____ $_____
☐ Other Vehicle or Recreational Vehicle:
Make: _____ Year: _____ $_____

MONTHLY PAYMENTS:

Rent/ Mortgage $_____ Water/Sewer/Garbage $_____ Groceries $_____
Electricity $_____ Telephone $_____ Cable TV $_____

(Use another sheet of paper if needed)

CREDITORS:	**UNPAID BAL:**	**MO. PYMT:**	**CREDITORS:**	**UNPAID BAL:**	**MO. PYMT:**
Child Care	$_____	$_____	Child Support	$_____	$_____
Visa	$_____	$_____	Visa	$_____	$_____
Master Card	$_____	$_____	Master Card	$_____	$_____
American Exp.	$_____	$_____	American Exp.	$_____	$_____
Auto Loan	$_____	$_____	Bank Loan	$_____	$_____
Auto Loan	$_____	$_____	Bank Loan	$_____	$_____
Retail Acct(name) _____	$_____	$_____	Credit Card(name) _____	$_____	$_____
Retail Acct(name) _____	$_____	$_____	Credit Card(name) _____	$_____	$_____
Other: (specify) _____	$_____	$_____	Other: (specify) _____	$_____	$_____

MEDICAL EXPENSES: Name of Facility	**Unpaid balance after Insurance:**	**MEDICAL EXPENSES: Name of Facility**	**Unpaid balance after Insurance:**
Central Washington Hosp	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____

GROSS INCOME FOR THE PREVIOUS 12 MONTHS: $_____

Verification of your TOTAL HOUSEHOLD income is required: Please send check stubs showing total gross income, and/or copy of Social Security check(s), and/or copy of bank statement for direct deposits, and/or W-2 tax forms, and/or a statement from your employer(s), and/or last year's income tax return. YOUR APPLICATION WILL NOT BE PROCESSED WITHOUT THIS DOCUMENTATION.

I understand that the information which I submit is subject to verification by Central Washington Hospital and subject to review by Federal and/or State enforcement agencies and others as required. I certify that the above information is true and correct.

Date: _____ Applicant Signature: _____

If you have questions concerning completion of this form, please call _____ at _____ Monday through Friday 8:30 a.m. to 4:00 p.m. Closed holidays and weekends.

Thank you.

This form and supporting documentation must be returned by _____ for consideration.