Attachment C

Colorado River Medical Center
Financial Assistance Application

Patient Name	Patient Account Number	Application Date
Telephone Number	Social Security Number	Birth Date (Month/Day/Year)
(street address) (City) (state) (zip)		❑ Employed ❑ Unemployed
Employer (Name, Address and Telephone Number)		
Spouse Name	Social Security Number	Birth Date (Month/Day/Year
Patient's Father (If patient is a minor)	Social Security Number	Birth Date (Month/Day/Year
Patient's Mother (If patient is a minor)	Social Security Number	Birth Date (Month/Day/Year)

A. Wages: Please provide the wages for each person in your household

PATIENT WAGES:		
	Annual Salary	Hourly Rate of Pay
	$	$
	Monthly Salary	Avg Hours Per Wk
	$	#

OTHER WAGES:		
	$	$
Name	Annual Salary	Hourly Rate of Pay
Relationship	$	#
	Monthly Salary	Avg Hours Per Wk
Employer		

OTHER WAGES:		
	$	$
Name	Annual Salary	Hourly Rate of Pay
Relationship	$	#
	Monthly Salary	Avg Hours Per Wk
Employer		

OTHER WAGES:		
	$	
Name	Annual Salary	Hourly Rate of Pay
Relationship	$	#
	Monthly Salary	Avg Hours Per Wk
Employer		

B. *Other Resources:* Please provide the total amount of other resources available to you, including savings accounts, checking accounts, stocks, bonds, trust funds etc. $_____ Source:_____
Please provide the amount of yearly income you receive from these other resources, including interest income, dividends, rental income, etc.
$ _____

C. Household Members: Please provide the number of persons in the patient's household: _____

D. Income Verification: Please provide the following documents to verify household income:

- IRS Form W-2
- Paycheck Stubs (recent 4)
- Tax Return
- Bank Statements
- Employer Verification
- Proof of Participation in Governmental Assistance programs such as food stamps, CDIC, Medicaid or AFDC
- Social Security or Unemployment Compensation Determination Letters
- Other, Please Describe: _____

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

I understand Colorado River Medical Center may verify the financial information contained in this Financial Assistance Application ("Application") in connection with Hospital's evaluation of this Application, and by my signature I hereby authorize my employer to certify the information provided in this Application. I also authorize Hospital to request reports from credit reporting agencies and the Social Security Administration. I certify that this information is true to the best of my knowledge and I am aware that falsification of information on this Application may result in denial of financial assistance.

_____ _____

Signature of Patient or Responsible Party Date Hospital/Representative – Title Date

Application/Proof of Income DUE DATE TO DISCHARGE OFFICE:_____