



Hayward Area Memorial Hospital

Financial Assistance Request Form

I. Patient Information					
PATIENT'S NAME LAST		FIRST		MI	PRIMARY CARE PHYSICIAN
STREET ADDRESS		CITY	STATE	ZIP	
DATE OF BIRTH	TELEPHONE - HOME	TELEPHONE - WORK		TELEPHONE - CELL	
II. Guarantor Information					
NAME OF PERSON RESPONSIBLE FOR PAYING THE BILL			RELATIONSHIP	Please check this box if you are applying to pre-qualify <input type="checkbox"/>	
STREET ADDRESS		CITY	STATE	ZIP	SOCIAL SECURITY NUMBER
DATE OF BIRTH	TELEPHONE - HOME	TELEPHONE - WORK		TELEPHONE - CELL	
III. Household Information – Please indicate ALL people living in your household, including applicant (use additional paper, if necessary)					
HOUSEHOLD MEMBERS	AGE	RELATIONSHIP TO PATIENT	EMPLOYER NAME	YEAR TO DATE INCOME	INSURED? IF YES, LIST INSURANCE (I.e. Blue Cross, Medica, etc.)
1.					Yes <input type="checkbox"/> No <input type="checkbox"/>
2.					Yes <input type="checkbox"/> No <input type="checkbox"/>
3.					Yes <input type="checkbox"/> No <input type="checkbox"/>
4.					Yes <input type="checkbox"/> No <input type="checkbox"/>
IV. EMPLOYER			SALARY WEEKLY \$		
V. SPOUSE'S EMPLOYER			SALARY WEEKLY \$		
VI. OTHER INCOME			AMOUNT \$		
VII. Expenses and Assets					
Rent/mortgage payment \$		Health Insurance Premium \$		Child Support received/paid \$	
<i>Please feel free to attach additional information regarding your current situation.</i>					
VIII. Required Documentation – Information that must be sent with this application					
Please check that you have included the following:					
<input type="checkbox"/> * Copy of previous year's tax returns FIRST PAGE ONLY		<input type="checkbox"/> Copy of latest bank statements <i>Your bank statement is used for proof of income statements only. Balance of cash assets are not part of the income process.</i>		<input type="checkbox"/> Income verification showing earnings or pay stubs for all income year-to-date. THIS IS ANY OTHER INCOME NOT REPORTED ON YOUR BANK STATEMENT AS DIRECT DEPOSIT.	
We may require additional documentation in order to assist you. If so, we will contact you at the telephone numbers you have listed. If you have questions regarding this form, please call 715-934-4267.					
* Please note: If your parent or someone else provides your basic living support, you must include their tax and income information.					
IX. Authorization					
I hereby certify the information contacted in the above financial questionnaire is correct and complete to the best of my knowledge. I authorize Hayward Area Memorial Hospital to verify any or all information given.					
RESPONSIBLE PERSON'S SIGNATURE _____				DATE _____	