

## FINANCIAL ASSISTANCE APPLICATION

To apply for Financial Assistance at Lower Umpqua Hospital:

1. Complete this application.
2. Attached copies of: Previous year's tax returns AND verification showing year to date income or last 3 months pay stubs.
3. Submit to Hospital Business Office

### GENERAL INFORMATION

Patient's name	Last	First	M.I.	Social Security Number	Date of birth
? Yes ? No					
U.S. Citizen	Marital status		Spouse's name Last First M.I.		Telephone No. Home / Work
Person responsible for paying the bill			Relationship to patient		Telephone No. Home / Work
Number of people in household			Ages of people in household		
Health insurance coverage (company name, ID#)					

### MONTHLY HOUSEHOLD INCOME

	PERSON 1	PERSON 2	PERSON 3
NAME:			
RELATIONSHIP TO PATIENT:			
<b>Monthly</b> gross income (attach verification)	\$ <u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
Unemployment, if so, how long _____	\$ <u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
Social Security, pensions	\$ <u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
Alimony/child support	\$ <u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
Government assistance, food stamps	\$ <u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
Other sources of income	\$ <u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
Checking account balances	\$ <u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
Savings account balances	\$ <u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
Stocks, bonds, IRA's, investments	\$ <u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
Other assets	\$ <u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>

**NOTE:** In the absence of income, a letter of support from individuals providing for the patient's basic living needs **is required**.

### MONTHLY EXPENSES / BILLS

? Rent \$ <u>                    </u>	? Monthly Mortgage \$ <u>                    </u>	Mortgage Balance \$ <u>                    </u>	Equity \$ <u>                    </u>
Utilities	\$ <u>                    </u>	Alimony/Child support	\$ <u>                    </u>
Credit cards (total)	\$ <u>                    </u>	Health insurance	\$ <u>                    </u>
Insurance (vehicle/life/property)	\$ <u>                    </u>	Healthcare bills	\$ <u>                    </u>
Child care	\$ <u>                    </u>	Medications	\$ <u>                    </u>
Living, i.e. gas, food, clothes	\$ <u>                    </u>	Entertainment	\$ <u>                    </u>
Car (Include Make/Year)	\$ <u>                    </u>	Other	\$ <u>                    </u>

**EXTENUATING CIRCUMSTANCES:** Attach a separate page explaining any extenuating situation that you would like us to consider in making our determination

**X** \_\_\_\_\_ Date \_\_\_\_\_  
**Responsible Person's Signature** (Required)

I certify the information contained above is correct and complete to the best of my knowledge, and may be verified by hospital. I hereby grant the Hospital permission to review my credit report for the purpose of verifying information I have provided.