SKY LAKES MEDICAL CENTER

FINANCIAL ASSISTANCE APPLICATION

Please answer the questions below as completely as possible. All information will be kept confidential. If you have any questions, please call 541.274.6699, Monday through Friday, 8:AM to 4:30 PM.

Date	Patient's Name	Last	First	M.I.	Social Security Number (optional)

Date of Birth	Patient's Account Number	Marital Status (optional)

Person responsible for paying the bill and relationship — Address — Telephone Number (Home / Work)

Telephone Number (Home / Work)

Names of people employed, full time or part time in household	Relationship	Social Security Number (optional)

Number of People in Household

Ages of children in household

HOUSEHOLD INCOME **Please provide the following information for each person, if applicable**

Attach verification of all types of income	**Person 1**	**Person 2**	**Person 3**
Monthly income, gross			
Unemployment benefits			
Social Security, pensions			
Government assistance, disability income			

PLEASE ATTACH A COPY OF:

- ❑ Income verification for the past 3 months for each person (in pay stubs)
- ❑ Wage record from employment office if no income
- ❑ Tax returns for the last 2 years

Business Office Use Only

Date Rec'd _____ Verified _____

Approved ❑
Denied ❑
Notified ❑

The above application is true to the best of my knowledge. If the hospital seeks verification of the information, I authorize any party contacted by the hospital to release the requested verification to the hospital.

Date: _____ Applicants Signature: _____