WAHIAWA GENERAL HOSPITAL

FINANCIAL ASSISTANCE APPLICATION

DATE OF REQUEST: _____________________

PATIENT'S NAME: _____________________________________TELEPHONE: ________________________

ADDRESS: ____(street)

____(city, state, zip code)

MARTIAL STATUS: _________ SOC SEC #: __ __ __-__ __-__ __ __ __

ACCOUNT #:________________________ DATE(S) OF SERVICE: ______________________

DO YOU HAVE HEALTH INSURANCE? YES_____ NO_____ (If YES, need copy of card)

NAME OF SPOUSE OR GUARNTOR: ________________________

NAME ALL SOURCE(S) OF INCOME: ____

PATIENT'S EMPLOYER: _________________________ LAST DAY WORKED: _____________

SPOUSE'S EMPLOYER: __________________________ LAST DAY WORKED: _____________

GROSS ANNUAL FAMILY INCOME (**include proof of income such as: check stubs, W-2 forms, income tax returns, etc.**):

SELF: $________________

SPOUSE: $________________

OTHER: $________________

TOTAL: $________________

NUMBER OF LEGAL DEPENDENTS ON INCOME (Include Self):__________

PROVIDER OF FINANCIAL INFORMATION (If other than patient or guarantor):

NAME: ____

ADDRESS: ____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT IS SUBJECT TO VERIFICATION BY WAHIAWA GENERAL HOSPITAL AND SUBJECT TO REVIEW BY GOVERNMENTAL AGENCIES.

REQUESTED BY: ____ DATE____________

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DO NOT COMPLETE (To be completed by Hospital Personnel only.)

This document was received on: ___________By:____

(Name & Title)