8/15/2018

Please fill this form out and attach income verification information which can be a (Tax Return, Pay Check Stub, W2's, Social Security Income or Disability Income Verification Letters).

You will also need to apply for AHCCCS and attach your denial or approval letter before we can process your application.

Once you have filled out the form, please return to the front desk at the Clinic or Business Office in the Hospital.

If you have questions please contact the Business Office at the hospital 928-684-5421 or clinic 928-668-1833.

Once the Financial Disclosure Worksheet is received it will be reviewed based on the Federal Poverty Guidelines. Upon determination, a letter will be sent to you with an explanation.

Sincerely,

Wickenburg Community Hospital & Clinics

Wickenburg Community Hospital

FINANCIAL DISCLOSURE WORKSHEET

Patient Information			**Today's Date:** / /	
First Name:	Middle:	Last:	Other names:	
Home Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
Home Phone #: ( ) -		Home Phone #: ( ) -		
Date of Birth: / /	Social Security # - -		Do you have insurance? (circle one) Yes No	
Marital Status:	Single In a relationship Married Divorced Separated Widowed			

Household Size		
Name	**Date of Birth**	**Social Security Number**
	/ /	- -
	/ /	- -
	/ /	- -
	/ /	- -

Household Income

Name	**Amount**	**Frequency (Circle one)**	**Employer or Source of Income:**
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	**You**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	**$**

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.

Your yearly income tax return, a copy of your W-2 form, last month's paycheck stubs, copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income and your family size will be used to calculate your discount.

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Wickenburg Community Hospital and Community Hospital Clinics if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Wickenburg Community Hospital and Community Hospital Clinics. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date: _____ Name (Print):_____

Signature: _____

For Provider Use Only		
Total Monthly Income	Number in Household	Total Expenses
Proof of Monthly Income Attached:	Yes	No
Proof of Monthly Expenses Attached:	Yes	No
Total Approved for Charity: $		

Signature of Approval Representative:	Date: