Wickenburg Community Hospital & Clinics

FAP Application Cover Sheet

Please fill this form out and attach copies of the following documents:

1. Previous Years Tax Return or W2
2. Paycheck stubs for last 3 months
3. SSI check or SSI Benefits Letter
4. Any other income
5. Bank statements for the last 6 months
6. Copy of denial or approval letter from Medicaid (AHCCCS)

If you have not applied for AHCCCS, please contact me to set up an appointment to complete the application process.

Once you have completed the FAP form, please return to Angelica Moreno.

If you have any questions, please feel free to contact me at 928-668.1824.

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…

All insurances to be billed first. Any balances thereafter; will be subject to FAP discounts.

Sincerely,

Angelica Moreno
Patient Financial Advisor
Wickenburg Community Hospital
Email: angelica.moreno@wickhosp.com
FAX: 928-684-2434

Financial Disclosure Worksheet

Please complete and return with a copy of your most recent pay stubs, last years tax return, W2's, the last 6 months of bank statements.

SECTION A	APPLICANT INFORMATION	
PATIENT NAME	ACCOUNT #	ACCOUNT BALANCE
MAILING ADDRESS		
PHYSICAL ADDRESS		
HOME PHONE:	CELL PHONE:	WORK PHONE:
GUARANTOR NAME		
GUARANTOR ADDRESS (IF DIFFERENT)		
SPOUSE'S NAME		
GUARANTOR EMPLOYER		
SPOUSE'S EMPLOYER		
SECTION B	HOUSEHOLD INFORMATION	
NAME: LAST, FIRST	RELATIONSHIP	AGE
SECTION C	SOURCE OF INCOME	
SOURCE	*GROSS MONTHLY INCOME*	
Guarantor		
Spouse		
Pensions/Retirement		
Social Security		
Disability		
Public Assistance		
Child/Spousal Support		
Rental Property Income		
IRA/CD's/Stocks/Bonds		
All other income sources		
SECTION D	ASSETS	
BALANCE IN ACCOUNTS	ESTIMATED VALUE OF PROPERTY	
CHECKING:	Home:	
SAVINGS:	Vehicle #1:	
IRA:	Vehicle #2:	
401K:		
403B:		
Stocks/Bonds/CD/Mutual Funds/Money Market:		

SECTION E	EXPENSES	
Description	*Balance Owed*	*Monthly Payment*
Rent/Mortgage		
Home Equity Value		
Vehicle(s): Make, Yr, Model		
Food & Other Household		
Fuel for Transportation		
Utilities		
Phone		
Child Care		
Child/Spousal Support		
Medical Bills paid in last 12 months		
Outstanding balances on past medical		
Credit Cards		
Other Expenses		
TOTAL MONTHLY EXPENSES		

I certify that the information provided in this financial disclosure worksheet and on any attachments is complete to the best of my knowledge. By signing below, I authorize Wickenburg Community Hospital to verify my credit and employment history. I further understand that this does not qualify me for future assistance for future visits.

SIGNATURE OF APPLICANT OR LEGAL GUARDIAN DATE:

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FOR PROVIDER USE ONLY

ANNUAL HOUSEHOLD INCOME:	NUMBER IN HOUSEHOLD:
AVERAGE MONTHLY INCOME:	
MONTHLY EXPENSES:	
AVAILABLE MONTHLY:	
PROOF OF MONTHLY INCOME AND EXPENSES ATTACHED:	
TOTAL APPROVED FOR CHARITY/REDUCED INSTALLMENT:	
DETERMINATION LETTER MAILED TO PATIENT:	DATE:
BUSINESS OFFICE MANAGER APPROVAL:	DATE: