Wheatland Memorial Healthcare
Compassionate Care Discount Program Application

Date of Request: ________________________

I ____ hereby request that Wheatland Memorial Healthcare make a determination of my eligibility for the Compassionate Care Program. I understand that the information which I submit will be subject to verification by Wheatland Memorial Healthcare, and if the information which I submit is determined to be false, it will result in a denial of the Compassionate Care Program and removal of any discounts I received under this false application.

This information is confidential. **Please complete all information, attach copies of supporting documents, sign, date and return this form by:** ________________________________

Household Members to be Considered in this Application

Patient / Guarantor: ____
Name | Social Sec # | Date of Birth

Spouse: ____
Name | Social Sec # | Date of Birth

Address: ____
Street | City | State | Zip | Phone Number

Patient / Guarantor Employer: ____
Name | Address | Occupation | Phone Number

Spouse's Employer: ____
Name | Address | Occupation | Phone Number

Marital Status:(Check one) ___ Married ___ Single ___ Divorced ___ Widow(er)

Number of persons in the household (include yourself) ____ Adults ____ Children

Do you have any type of health insurance such as Blue Cross, Medicare, Medicaid, or commercial insurance? __________ Yes __________ No If yes, please specify below:

Insurance name ___________________________________ Policy #_________________________________

Insurance name ___________________________________ Policy #_________________________________

Wheatland Memorial Healthcare

Financial Information - Monthly Income for Household
(Attach copies of check stubs for the last 3 months)

Sources of Income	Guarantor	Spouse	Others	TOTAL
Gross Monthly Wages				
Self Employment Income				
Public Assistance				
Social Security				
Unemployment				
Workmen's Compensation				
Child Support				
Pensions / Retirement				
Rental Income				
Other Sources				
Total Monthly Income				

NOTE: Individuals claiming zero ($0) income must file a Form 4506-T.

Additional Information

If you expect a change in income, health, other circumstances, or cannot provide the requested information, then please explain. Attach additional pages to this application, if you require more space for your information.

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I (we) certify that the information provided is true and accurate to the best of my (our) knowledge. I (we) hereby authorize the hospital and / or its agents to verify the information provided in this application. I (we) hereby authorize that verification can include, but not limited to, the inquiry of my (our) credit history through a credit reporting agency. If any of the information given proves to be untrue, then I (we) understand that the hospital may re-evaluate my (our) financial status and take whatever action it deems appropriate.

______________________________	______________________________
Print Name	Print Name
______________________________	______________________________
Signature	Signature
______________________________	______________________________
Date	Date

TO BE COMPLETED - FACILITY PERSONNEL ONLY

This document was received on______________________________ by _____________________________________