



# Windom Area Hospital

WINDOM: 507.831.2400 | MT. LAKE: 507.427.2700

contactus@windomareahospital.com

2150 Hospital Drive Windom, MN 56101

Note: Any falsification of information can result in forfeiture of your eligibility.

Guarantor Name	Guarantor Occupation
Address	Phone
Spouse Name	Spouse Occupation
Patient Name(s)	
Full Name of Dependents & Age	

Please list all of the following information as it pertains to your financial status today. Please submit any verification of the information that may be available.

Monthly Income (self)	Do you own or rent your home?    OWN    RENT Monthly paymt \$                    Market Value \$ Net worth of business owned \$ Vehicle(s) owned (make & year):  Other Assets:
Spouse's Monthly Income	
Other Income	
Nature of Other Income	
<b>Total Monthly Earnings \$</b>	

List banks, stores, charge cards, etc. where you have accounts.

	<u>Account With</u>	<u>Balance</u>	
Checking Account	_____	\$ _____	
Savings Account	_____	\$ _____	
Investments(stocks/bonds/securities)	_____	\$ _____	
	<u>Account With</u>	<u>Balance Owing</u>	<u>Monthly Payment</u>
Auto Loan	_____	_____	_____
Auto Loan	_____	_____	_____
Other Loans	_____	_____	_____
Other Loans	_____	_____	_____
Credit Cards	_____	_____	_____
Credit Cards	_____	_____	_____
Credit Cards	_____	_____	_____
Credit Cards	_____	_____	_____
Other Obligations (include alimony, child support payments, etc)	_____	_____	_____
<b>Total Payments \$</b>	_____	_____	_____

Medical Expenses- Name of Entity Owing to:	<u>Balance Owing</u>	<u>Monthly Payment</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you anticipate receiving any gifts, inheritances or money from land sales or any other source in the near future?  
If yes, please explain.

Are you a member of a Health Cost Sharing Organization (such as Christianhealthcare, Medi-Share, Liberty)?

Have you ever declared bankruptcy? YES NO If so, when?

Have you ever received welfare benefits from any governmental or other third party source (county welfare payments, food stamps, Medicaid, Emergency Energy Assistance, etc.)?

The above information will be kept confidential & will only be used in the determination of full or partial forgiveness of a medical obligation to Windom Area Hospital. The undersigned certifies that the information has been carefully read and is true and correct to the best knowledge of the undersigned.

Signature \_\_\_\_\_ Date \_\_\_\_\_

<b>(FOR OFFICE USE ONLY)</b>	<b>APPROVED</b>	<b>APPROVED W/ ADJUSTMT</b>	<b>DENIED</b>
Patient Account # _____	Amount on Patient Account \$ _____		
COMMENTS _____			

Please attach the following additional information:

- \_\_\_\_\_ Copy of pay stub
- \_\_\_\_\_ Copies of current bank statements
- \_\_\_\_\_ Copy of most recent tax return
- \_\_\_\_\_ Copy of letter denying coverage for medical assistance benefits