Windom Area Health
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
Spouse's Monthly Income	Monthly paymt $ Market Value $
Other Income	Net worth of business owned $
Nature of Other Income	Vehicle(s) owned (make & year):
Total Monthly Earnings $	
	Other Assets:

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

	Account With	***Balance***
Checking Account		$
Savings Account		$
Investments(stocks/bonds/securities)		$

	Account With	***Balance Owing***	***Monthly Payment***
Auto Loan			
Auto Loan			
Other Loans			
Other Loans			
Credit Cards			
Credit Cards			
Credit Cards			
Credit Cards			
Other Obligations (include alimony, child support payments, etc)			
Total Payments $			

Medical Expenses- Name of Entity Owing to:	***Balance Owing***	***Monthly Payment***

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 Health. The undersigned certifies that the information has been carefully read and is true and correct to the best knowledge of the undersigned.

Signature _____ Date _____

(FOR OFFICE USE ONLY) **APPROVED** **APPROVED W/ ADJUSTMT** **DENIED**

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