MID-COLUMBIA MEDICAL CENTER

STATEMENT OF FINANCIAL RESOURCES

ACCOUNT NO.

MED. REC. NO.

NAME

BIRTHDATE

Patient / Applicant Information

TODAY'S DATE: _____ / _____ / _____ **DATE OF SERVICE: (IF KNOWN)**_____ / _____ / _____

SECTION 1 - FAMILY INFORMATION

Number of people in household: _____

List household members:

NAME	RELATIONSHIP	DATE OF BIRTH	AGE
_____	SELF / PATIENT	_____ / _____ / _____	_____
_____	_____	_____ / _____ / _____	_____
_____	_____	_____ / _____ / _____	_____
_____	_____	_____ / _____ / _____	_____
_____	_____	_____ / _____ / _____	_____
_____	_____	_____ / _____ / _____	_____

Is anyone in the family currently pregnant? Yes / No

If yes, please indicate which family member _____

Are any of the above family members claimed on another individual's income tax return? Yes / No

If so, please indicate which family members _____

Were taxes filed for the family for the most recent tax year? Yes / No

If no, please explain why not _____

_____

SECTION 2 - RESIDENCE

Primary Residence:

☐ **Own Home** ☐ **Renting** **Amount of Monthly Rent** _____ **Other** _____

Physical Address of Primary Residence: _____

☐ **Own 2nd Home** _____ (City) _____ (State)

☐ **Own Rental Home**

NAME: _____ DATE: ____/____/____

SECTION 3 - EMPLOYMENT INCOME

HEAD OF HOUSEHOLD:

Name: _____ Relationship to Patient: _____

Gross Income for the last three complete calendar months:

Month/Year _____ $ _____ Month/Year _____ $ _____ Month/Year _____ $ _____

Current Month Anticipated Income $ _____

Current Employer: _____

Employment Dates: From: _____ To: _____

Employment Comments: _____

_____

SPOUSE/OTHER:

Name: _____ Relationship to Patient: _____

Gross Income for the last three complete calendar months:

Month/Year _____ $ _____ Month/Year _____ $ _____ Month/Year _____ $ _____

Current Month Anticipated income $ _____

Current Employer: _____

Employment Dates: From: _____ To: _____

Employment Comments: _____

SECTION 4 - OTHER INCOME MONTHLY

SOURCE	A HEAD OF FAMILY	B SPOUSE/OTHER	A+B TOTAL MONTHLY $
Social Security Income	$ _____	$ _____	$ _____
Rental Income	$ _____	$ _____	$ _____
Unemployment Compensation	$ _____	$ _____	$ _____
Retirement Income	$ _____	$ _____	$ _____
Alimony	$ _____	$ _____	$ _____
Child Support	$ _____	$ _____	$ _____
Interest/Dividends	$ _____	$ _____	$ _____
Other Income	$ _____	$ _____	$ _____

(Specify Income Source) _____

TOTAL MONTHLY INCOME $ _____

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NAME: _____ **DATE:** _____ / _____ / _____

SECTION 5 - TOTAL ASSETS

SOURCE	AMOUNT/VALUE	SOURCE	AMOUNT/VALUE
Cash	$ _____	Life Insurance (cash value)	$ _____
Checking Account	$ _____	Certificate of Deposit	$ _____
Savings Account	$ _____	Other (specify)	$ _____
		_____	$ _____
		_____	$ _____

SOURCE	NET VALUE	MONTHLY PAYMENT	COMMENTS/DESCRIPTION
Home	$ _____	$ _____	_____
Land	$ _____	$ _____	_____
Business Equity	$ _____	$ _____	_____
Vehicles	$ _____	$ _____	_____
Other Assets	$ _____	$ _____	_____

SECTION 6 - COMMENTS YOU WISH TO MAKE

_____

_____

_____

_____

I certify that the above information is true and accurate to the best of my knowledge. **I agree to notify MCMC if my circumstances change, for example, if I move away from Oregon or obtain new employment.** Further, I will make application for any assistance (Medicaid, Medicare, Insurance, Etc.) which may be available for payment of my hospital/clinic/provider charges, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital/clinic/provider the amount recovered for hospital/clinic/provider charges. If any information I have given proves to be untrue, I understand that the hospital/clinic/provider may re-evaluate my financial status and take whatever action becomes appropriate.

NOTE: A DEPOSIT MAY BE REQUIRED FOR SERVICES RECEIVED PRIOR TO FINANCIAL ALLOWANCE DETERMINATION.

Applicant's Signature: _____ Date of Request: _____