WISHEK HOSPITAL CLINIC ASSOCIATION
1007 4th Ave S
PO Box 647
Wishek, ND 58495
701-452-2326 or 800-492-2364

Uncompensated Care Income and Expense Application

CONFIDENTIAL

Guarantor Name ____ Account # __________________

Mailing Address ____ Phone # ___________________

Dependents

	Name	Birth Date	Relationship
1.	______________________	______________	________________
2.	______________________	______________	________________
3.	______________________	______________	________________
4.	______________________	______________	________________
5.	______________________	______________	________________
6.	______________________	______________	________________

Monthly Family Income

Patient employment	$ ____________________
Spouse's employment	____________________
Retirement income	____________________
Dividends, interest	____________________
Alimony	____________________
Child Support	____________________
Workers Compensation	____________________
Social Security	____________________
Unemployment	____________________
Public Assistance	____________________
Rental land/buildings	____________________
Other (specify)	____________________
Other (specify)	____________________
Total Income	**$** ____________________ **A**

Cash on hand or in bank accounts	$_____________
Stocks/bonds/securities (cash value)	$_____________
Cash value of real estate (where we live)	$_____________
Life Insurance policies (cash value)	$_____________

NOTE: Attach copies of income verification for the past 3 months
Attach a copy of your most recent income tax return

Monthly Expenses

Vehicles	Vehicle "A"	Vehicle "B"	Vehicle "C"
Year	___	___	___
Make	___	___	___
Model	___	___	___
Balance Owing	$___	$___	$___
Monthly Payment	$___	$___	$___

Mortgage/Rent

Balance Owing $___

Monthly Payment $___

Car payments	$___
Mortgage/Rent	___
Utilities	___
Food	___
Insurance (All)	___
Medical	___
Pharmacy/Dentist/Eye	___
Transportation	___
Credit Cards	___
Installment debts	___
Child Support/Alimony	___
Other debts	___
	___
Total Expenses	**$___B**

Total Income **A** ___

Less Expenses **B** ___

Net Monthly Income $ ___

Comments (will be kept confidential): ___

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___

___

What amount monthly do you feel you can afford to pay us? ___

I/We hereby acknowledge that the information provided to Wishek Hospital Clinic Association on this Uncompensated Care application is true and correct, and authorize the release of information from financial institutions, creditors, and employers to Wishek Hospital Clinic Association for the purpose of verifying the accuracy of information provided in this application.

Applicant's signature: ___ **Date:** ___