

Wyoming Medical Center

Confidential Charity Care Assistance Questionnaire

Patient Name _____ **Account Number(s)** _____

Applicant's Full Name	Date of Birth	Social Security No.	No. of Dependents
Co Applicant's Full Name	Date of Birth	Social Security No.	No. of Dependents
Street Address	City	State, Zip	Telephone No.
Employer	Position	No. of Years	Gross Wages per Month
Employer's Street Address	City	State, Zip	Telephone No.
Co-Applicant Information/Other Adults in the Household	Amount/Mo.	Bank Name(s)	City, State
Other Sources of Income (describe)	Amount/Mo.		

Assets	Amount	Liabilities	Amount
Cash			
Investments (describe)			
Home (current value)		Home Mortgage/Rent	
Other Real Estate			
Automobiles (year, make, model)		Auto Loans	
Automobiles cont'			
Business (net assets)		Business Loans	
Other (describe)		Other Debt (describe)	

Please Attach a copy of your most recent federal tax return, W2 , pay stubs or letter from employer.

You may be required to apply for Medicaid assistance before your request for Charity Care can be approved.

I certify that the information in this application is true and complete.

Signature of Applicant _____ Date _____

Signature of Co-Applicant _____ Date _____