Westfields Hospital™

Part of the HealthPartners Family of Care

Financial Statement

PERSONAL INFORMATION

Patient's Name: _____ Date of Birth: _____
Address (Street, City, State, Zip): _____
Phone (Home & Cell): _____
Spouse's Name: _____ Date of Birth: _____
Dependents (Name, Date of Birth): _____
_____

EMPLOYMENT INFORMATION

	Responsible Party/Guardian	Spouse
Occupation/Job Title	_____	_____
Employer	_____	_____
Employer Phone No.	_____	_____
Hourly Wage	_____	_____
Hours worked monthly	_____	_____
How long employed	_____	_____
If unemployed, last date worked	_____	_____

SOURCE OF MONTHLY INCOME

	Responsible Party/Guardian	Spouse
Gross Employment Income	_____	_____
Social Security	_____	_____
Disability	_____	_____
Pension	_____	_____
Unemployment (From_____ to _____)	_____	_____
Child Support/Alimony	_____	_____
VA Benefits	_____	_____
Other	_____	_____

* If zero or no income, please explain how you provide for your living expenses: _____
_____
_____
_____

ASSETS

Checking _____
Savings _____
IRA's _____
Stocks/Bonds/CDs _____
If you own your home:
Location: _____
_____
Fair Market Value: _____
Mortgage Balance: _____

Auto Model & Year _____
Amount owed_____
2nd Auto Model & Year_____
Other Assets _____
_____
Value of other Assets: _____
Amount owed: _____
Other real estate: _____
Fair Market Value: _____
Mortgage Balance: _____

LIABILITIES

Mortgage/Rent: _____ Auto: _____
Utilities: _____ Child Care: _____
Credit Card(s): _____ Child Support: _____
Medication Cost: _____ Alimony: _____
Bank Loans: _____ Other Debts: _____
(medical bills, loans, fines, taxes, etc.)

Insurance Premiums: Life _____ Health _____ Auto _____ Property _____ Other _____

ADDITIONAL INFORMATION

Was health insurance available through employer and waived as a benefit? _____
Have you applied for any State/County Assistance Programs? _____
Date applied: _____ Application accepted: _____ or Denied _____
Name of County that benefits were applied for in: _____

Please comment on any other items regarding your financial situation, which you feel should be taken into consideration in the determination of your application for uncompensated care:

_____
_____
_____
_____
_____

I authorize Westfields Hospital to verify any information given on this financial statement. I attest that the above information is accurate to the best of my knowledge and truly represents my current financial status. This financial information, along with information obtained through the verification process, will only be used for the sole purpose of determining if the services received would be provided at a discounted rate.

Responsible Party: _____ Date: _____

Please attach a copy of your latest federal tax return. If you did not file taxes a written statement from you stating no taxes filed and the last date you did file taxes. A copy of your W-2's and a copy of your most recent pay stub/ or bank statement if on Social Security or self-employed.

Please mail the completed financial statement and supporting documentation to:

Westfields Hospital
Financial Counselor
535 Hospital Road
New Richmond WI 54017