



FINANCIAL ASSISTANCE APPLICATION
 Blue Mountain Hospital and Strawberry Wilderness Community Clinic

Name of Head of Household	Place of Employment
Spouse	Place of Employment
Mailing Address including City, State, Zip Code	Phone: Cell phone or other

Please list spouse and dependents included on your tax return

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Household Income for past three months:

Source	Self	Spouse	Other	Total
Gross Wages, salaries, tips, etc.				
Unemployment, workers' compensation,				
Social Security, public assistance, pension or retirement income				
Rents, royalties, income from estates, trusts, alimony, child support and miscellaneous sources				

NOTE: Copies of tax returns, pay stubs, bank statements, or other information verifying income is required.

If you do not have health insurance, have you applied for Oregon Health Plan or any other insurance coverage in the past 30 days? Attach their response. Yes ___ No ___

I certify the family size and income information shown above is correct.

Name (Print) _____

Signature _____ **Date** _____

Completed Applications may be submitted in person or by mail to Blue Mountain Hospital District's Business Office

Office Use Only

Patient's Name: _____

Approved Discount: _____

Approved by: _____ **Date:** _____