FINANCIAL ASSISTANCE APPLICATION

Blue Mountain Hospital and Strawberry Wilderness Community Clinic

Name of Head of Household	**Place of Employment**
Spouse	**Place of Employment**
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.

Insurance: If you have insurance please provide copies of your cards
If you do not have health insurance, have you applied for Cover Oregon (Oregon Health Plan) or any other insurance coverage in the past 30 days? Attach their response. Yes _____ No_____

I certify that the family size and income information show 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

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Office Use Only

Patient's Name:_____

Approved Discount:_____

Approved by:_____ Date:_____

Verification Check list	Yes	No
Identification/Address: Driver's License, utility bill, employment ID		
Income: Prior year tax return, three most recent paystubs, Social Security Award Letter, three most recent bank statements		