North Canyon Medical Center
Financial Information

Application Date:___/___/____ Account Number:_____ Balanced Owed:_____

All questions must be answered. Forms that are not completely filled out will not be considered for smaller payments.

Responsible Party:_____ Date of Birth:___/___/_____

Social Security Number___-____-_____ Relationship to Patient_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

How long have you lived at the present address:_____ Phone Number:_____

Employer:_____ Employer phone number:_____

Job Title:_____ How long have you worked for this employer:_____

Spouse Name:_____ Date of Birth:___/___/____ SS#___-___-_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Phone Number_____ Employer:_____

Job Title:_____ How long have you worked for this employer:_____

Dependents:(Must be claimed on taxes)

Name:_____ Age:_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

Nearest relative or friend, other than spouse:_____ Phone Number:_____

Income (Proof of income needed):

Self $_____monthly Spouse $_____monthly

Other Income:

Social Security or Disability $_____monthly Unemployment $_____monthly

Work Comp $_____monthly Child Support $_____monthly Other_____monthly

Food Stamps $_____monthly Interest Income $_____monthly

Assets:

Do you own property ☐ Yes ☐ No If yes, location of property:_____

Checking Account ☐ Yes ☐ No Bank Name:_____

Savings Account ☐ Yes ☐ No Bank Name:_____

Certificates of Deposits ☐ Yes ☐ No Bank Name:_____

Continue on Back

Monthly Expenses: Fixed

Monthly Income $_____

	Monthly	Balance
Rent/House Payment	$_____	$_____
House Insurance Property Tax	$_____	$_____
Power	$_____	$_____
Heat	$_____	$_____
Phones	$_____	$_____
Water/Sewer/Trash	$_____	$_____
Automobile Payment #1	$_____	$_____
Automobile Payment #2	$_____	$_____
Automobile Insurance	$_____	$_____
Health Insurance	$_____	$_____
Child Support/Alimony	$_____	$_____
Total	$_____	(Subtract from income) $_____

Variables

Cable	$_____	$_____
Credit Card	$_____	$_____
Credit Card	$_____	$_____
Credit Card	$_____	$_____

Medical Bills (Please describe):

_____ $_____
_____ $_____
_____ $_____

Misc. Household (please describe):

_____ $_____
_____ $_____
_____ $_____

Other (please describe):

_____ $_____
_____ $_____
_____ $_____

Totals $_____ (Subtract from income) $_____

Comments:

_____
_____
_____
_____

Please provide proof of income with either 2 months of pay stubs or copies of income tax statements. By my signature below, I am swearing that the financial information provided is true and accurate to the best of my knowledge. Providing untrue and/or inaccurate information disqualifies me from any further financial assistance.

Signature:_____ **Date**_____