

ATTACHMENT A
Minidoka Memorial Hospital

FINANCIAL HARDSHIP ASSISTANCE APPLICATION

Name: _____ Date: _____

Address: _____ Phone: _____

Previous Address: _____

Employer: _____ Address: _____

If unemployed, how long? _____

Number of Dependents: _____ Adults _____ Children _____ Ages _____

Social Security Number: _____ Spouse Social Security Number: _____

INCOME: _____

Salary (net) \$ _____

Spouse Salary (net) \$ _____

Social Security Income \$ _____

Government Assistance \$ _____

Child Support \$ _____

Other \$ _____

Total Income \$ _____

Verified by: Pay Check Stub
 Income Tax Return
 Other

Information Needed With Application

Last year's Income Tax Return

Proof of Income

Denial from Medicaid and County Assistance

An IRS 1099 form will be filed with the Federal Government disclosing the Financial Hardship Assistance or Charity Care provided to the patient(s).