

Demographic Information

Patient Name:	
Account #	Birthdate:
Applicant Name:	
Relationship to Patient:	
Address:	
City:	State:
Phone #	

Employment

Patient	Spouse
Employer:	Employer:
Address:	Address:
Full/Part Time:	Full/Part Time:
Retired? Date of Retirement:	Retired? Date of Retirement:

Household

Do you rent or own your current residence? RENT OWN

Do you have any other real estate? YES NO

<u>Dependents living in your home</u>	<u>Relationship</u>	<u>Age</u>

Income & Expenses

Monthly Income

Proof of all income is required for a complete application

Patient	Spouse
Wages:	Wages:
Social Security:	Social Security:
Disability:	Disability:
Pension:	Pension:
Other:	Other:
Total:	Total:
Total Household Income:	

Monthly Expenses

Rent/Mortgage:	Transportation:
Utilities - Water:	Electricity: Gas:
Telephone:	Cable/Internet:
Insurance – Auto:	Health: Other:
Groceries:	
Medication (Not covered by insurance):	
Loan Installment Payments (Auto, Student, Credit Card)	
Name:	Payment:
Total Household Expenses:	

Medicaid

Have you applied for Medicaid Benefits? Yes No

If YES, what was the outcome of your application? _____

Outside Facility Assistance

Have you applied for assistance with a local hospital? Yes No

If YES, which hospital? _____

What was the outcome of your application? Approved Pending Denied

Please include approval award letter with this application

For your application to be processed in a timely manner and to avoid delays, please attach copies of all applicable information to support your income and expenses.

I hereby authorize Willamette Valley Cancer Institute and Research Center to inquire about my credit through a credit reporting agency (if needed) to verify the information I have provided. I understand this information will be used solely for the purpose intended and NOT released to an outside agency.

Signature: _____ Date: _____

Spouse/Guarantor: _____ Date: _____