Patient Medical Record #:
Patient CPI #:

WFBH FINANCIAL QUESTIONNAIRE

I attest that the answers given below are true and complete. I understand that and false or misleading information I have given may result in my not being eligible for any adjustments, discounts, or community benefits. I also understand that WFBH may check my credit history, among other things, to verify this information. Any adjustments, discounts or community benefits will not be approved if any of the statements in this document are shown to be false or misleading.

Patient Name- Please Print **Telephone Number** _____

First Middle Last Date of Birth (mm/dd/yyyy)

Home Address (No PO Box)

Street City State Zip

Patient Signature **Date**

_____ _____

Guarantor Name- Please Print **Guarantor Signature**

_____ _____

Question One: How many people are in your household? (This includes spouse, children in the home and any living outside the home that you are responsible for financially).

_____Number of people in the household

Question Two: How much do you and your spouse earn in a year? _____

Discount based on information provided and the current year Federal Poverty Income Guidelines.

Office Use Only

Income = or <200% ____	Income 201%-300% ____	Income 301%-400% ____	Income > 400% ____
100% Discount	75% Discount	50% Discount	0% Discount