MORROW COUNTY HEALTH DISTRICT

Excellence in Healthcare

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Heppner, Oregon 97836

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FINANCIAL ASSISTANCE APPLICATION

RESPONSIBLE PARTY INFORMATION	
Name	Phone Numbers
Mailing Address	
Current Employer	

Please list all household members, including those under the age of 18.

Name	Date of Birth	Name	Date of Birth
Self		Other	
Other		Other	
Other		Other	
Other		Other	

Annual Family Income – Enter actual dollar amounts

Source of Income	Self	Spouse	Dependent	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, VA benefits				
Alimony, child support, military allotments				
Income from self employment				
Rent, interest, dividends, and other income				
TOTAL INCOME				

Documentation required to be submitted with application

Identification (Provide one)	Driver's license, state ID card, or other photo ID	
Income (Provide all)	▪ 3 most recent pay stubs for all members of household ▪ 3 most recent bank statements ▪ Prior year tax return ▪ Social Security Benefits Summary (if applicable)	

I certify that the family size and income information shown above is correct.

Name (Print)	**Date**

Signature

OFFICE USE ONLY		
Patient Name(s)		
Date Approved	**Discount %**	**Approved by**