



Attachment 2

Date: \_\_\_\_\_

Charity Care Additional Application/Questionnaire

Applicant: \_\_\_\_\_

Co-Applicant: \_\_\_\_\_

Please provide this additional information to Wyoming Medical Center for consideration under our Charity Care Program:

- Wage check stubs, tax returns, and statement from employer
- Disability, sick pay or social security income
- Unemployment, settlement or pension income
- Public Aid income, child support
- Food stamps or heat assistance benefits
- Student loans and/or grants income
- Rental or self employment income
- Life insurance value
- Other:

Were you offered health insurance through your employer? Your employer might be contacted to verify this information.

If yes, did you accept or decline?

If you declined, please state the reason. You may also be required to provide evidence of the cost of this insurance.

Please return this requested information with in 21 days. Should you need further assistance please call

Patient Financial Service at (307)577-2421.

Thank You,  
Wyoming Medical Center  
Patient Financial Services.