WAYNE MEMORIAL
HOSPITAL

An Affiliate of Wayne Memorial Health System, Inc.

APPLICATION FOR FINANCIAL AID

DATE OF APPLICATION: ______________________________

NAME: ______________________________
Last First Middle

ADDRESS: ______________________________
Number & Street City State Zip Code

PATIENT'S DOB: ______________________________ (XX/YY/ZZZZ)

HAVE LIVED AT THIS ADDRESS SINCE: ______________________________
Date

TELEPHONE NUMBER: (__________)______________________________

OCCUPATION: ______________________________

EMPLOYER: ______________________________

DATE OF MEDICAL ASSISTANCE APPLICATION: ______________________________

DATE OF MEDICAL ASSISTANCE DETERMINATION: ______________________________
(Please include copy of determination notice.

INCOME: List income from the following sources:

	Total for Last 3 Months	Total for Last 12 Months
Wages	____________	____________
Social Security	____________	____________
Farm or Self-employment	____________	____________
Public Assistance	____________	____________
Workers' Compensation	____________	____________
Strike Benefits	____________	____________
Alimony	____________	____________
Child Support	____________	____________
Military Family Allotments	____________	____________
Pensions	____________	____________
Dividend or Interest Income	____________	____________
Rental Income	____________	____________

	Total for Last 3 Months	Total for Last 12 Months
CD'S	____________	____________
Bank Accounts Checking & Savings	____________	____________
Stocks & Bonds		
Cost-Current Market Value	____________	____________
Housing Own or Rent		
If own, estimate value	____________	____________
Automobile - Year, Make &		
Estimated Value	____________	____________

NOTE: Please include copies of your most recent federal and state income tax returns and supporting schedules. If you do not file an income tax, please explain below.

____

____

HOUSEHOLD MEMBERS: Families with more than 5 members attach additional sheet.

NAME	AGE	SOCIAL SECURITY #
1.		- -
2.		- -
3.		- -
4.		- -
5.		- -

I affirm that the above information is true and correct to the best of my knowledge.

____

DATE SIGNATURE

RETURN APPLICATION TO: Patient Account Manager
Wayne Memorial Hospital
601 Park Street
Honesdale, PA 18431