

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 DATE OF BIRTH:			(xx/yy/zzzz)
HAVE LIVED AT THIS ADDRESS SINCE			
TELEPHONE NUMBER: (Date	
OCCUPATION:			
EMPLOYER:			
DATE OF MEDICAL ASSISTANCE APP	LICATION:		
DATE OF MEDICAL ASSISTANCE REJE (Please include copy of determination notice)	ECTION:		
INCOME: List income from the follo	wing sources:		
	Total for <u>Last 3 Months</u>		Total for <u>Last 12 Months</u>
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			

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 along with supporting schedules. If you do not file an income tax return, please explain below. HOUSEHOLD MEMBERS: Families with more than 5 members attach an additional sheet. Name Age Social Security # 1. 2. 3. 4. Laffirm that the above information is true and correct to the best of my knowledge. DATE SIGNATURE RETURN APPLICATION TO: Wayne Memorial Hospital		Total for	Total for		
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2	<u>Name</u>	Age Socia	al Security #		
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, ,	DATE	SIGNATURE			
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	RETORIVALIE ECAHON TO.	Attn: Patient Account Manager	•		

601 Park Street Honesdale, PA 18431