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: ______________________________
Date

TELEPHONE NUMBER: (__________) ______________________________

OCCUPATION: ____

EMPLOYER: ____

DATE OF MEDICAL ASSISTANCE APPLICATION: ______________________________

DATE OF MEDICAL ASSISTANCE REJECTION: ______________________________
(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 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.		
5.		

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

____

DATE SIGNATURE

RETURN APPLICATION TO:

Wayne Memorial Hospital
Attn: Patient Account Manager
601 Park Street
Honesdale, PA 18431