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. (SELF)			
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