

Washington Health Systems

Charity Care Application
155 Wilson Avenue Washington, PA 15301

Account #: _____ **Return by:** _____

Last Name: _____ **First Name:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Daytime phone number: (_____) _____ **Number of Family Members:** _____

Date Applied for Medical Assistance: _____ **Denied:** Yes or No
 (**Please provide your Medical Assistance determination. **) (circle)

Please provide a complete copy of your most recently filed federal tax return and your last 2 months bank (checking/savings accounts) statements.

Please provide a complete copy of your most recently filed federal tax return.

Please provide documentation on proof of all Income.

<u>Household Income:</u>	<u>You</u>	<u>Spouse</u>	<u>Other Members</u>
Gross Salary/ Wages (please provide pay stubs for 3 months.)	\$	\$	\$
Pension	\$	\$	\$
Social Security Income	\$	\$	\$
Unemployment Comp.	\$	\$	\$
Disability Comp.	\$	\$	\$
Child Support/Alimony	\$	\$	\$
Interest/Dividends	\$	\$	\$
Other (Please describe)	\$	\$	\$
	\$	\$	\$

Please list all medical expenses below:

<u>Medical Expenses</u>	<u>Amount Owed</u>
Doctor/Facility	\$
Doctor/Facility	\$
Doctor/Facility	\$
Doctor/Facility	\$
Doctor/Facility	\$

If you have additional medical expenses please list on back of form.

APPLICANTS SIGNATURE: _____ **DATE:** _____

FOR HOSPITAL USE ONLY –DO NOT WRITE BELOW THIS LINE

Prepared by: _____ **Date:** _____

Annual household income: \$ _____ **Family size per tax return:** _____ **% FPG:** _____

APPROVED / DENIED: _____ **DATE:** _____