THE WASHINGTON HOSPITAL

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.

Household Income:	**You**	**Spouse**	**Other Members**
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:

Medical Expenses		**Amount Owed**
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:_____

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Prepared by: _____ Date:_____

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

APPROVED / DENIED: _____DATE: _____