WILLS MEMORIAL HOSPITAL

APPLICATION FOR

INDIGENT CARE ASSISTANCE

PATIENT NAME: LAST________________________ FIRST____________________ MIDDLE INITIAL____________________

GUARANTOR NAME: LAST________________________ FIRST____________________ MIDDLE INITIAL____________________

PRESENT STREET ADDRESS:____

CITY______________________________STATE__________________ ZIP CODE___________ YEARS LIVED HERE___________

HOME PH#:____________________ SOCIAL SECURITY #:________________________ DATE OF BIRTH:___________# OF DEP.______

PREVIOUS STREET ADDRESS:____

CITY______________________________STATE__________________ ZIP CODE___________ YEARS LIVED HERE___________

CURRENT EMPLOYER:___________________________EMPLOYER ADDRESS:____

CURRENT EMPLOYER PH#:____________________POSITION:___________________ LENGTH OF EMPLOYMENT:_____YRS_____MONTHS

PREVIOUS EMPLOYER:___________________________EMPLOYER ADDRESS:____

PREVIOUS EMPLOYER PH#:____________________POSITION:___________________ LENGTH OF EMPLOYMENT:_____YRS_____MONTHS

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU: ____

RELATIVE'S ADDRESS:_____________________________CITY:______________________STATE:______________ZIP CODE:__________

SALARY INFORMATION:

APPLICANT SALARY:$______________

NET_____ WEEKLY_____ MONTHLY_____ SEMI -ANNUALLY_____ GROSS_____ BI-WEEKLY_____ QUARTERLY_____ ANNUALLY_____

CO-APPLICANT SALARY:$______________

NET_____ WEEKLY_____ MONTHLY_____ SEMI -ANNUALLY_____ GROSS_____ BI-WEEKLY_____ QUARTERLY_____ ANNUALLY_____

LIST ANY OTHER MEANS OF INCOME:____

CHECKING ACCOUNT:
NAME OF INSTITUTION:____ ACCOUNT :__________________________

SAVING ACCOUNT:
NAME OF INSTITUTION:____ ACCOUNT :__________________________

CREDIT INFORMATION:
LANDLORD OR MORTGAGE HOLDER:______________________________________ PAYMENT:______________

RENT_____ BUY_____ PARENTS_____ OTHER_____

CAR LOAN:________________________ACCOUNT #:_________________BALANCE:__________________MONTHLY PAYMENT__________

OTHER CREDITORS:____

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THE ABOVE INFORMATION TO BEST OF MY KNOWLEDGE IS CORRECT.

THE ABOVE INFORMATION WILL BE KEPT CONFIDENTIAL AND WILL REMAIN IN YOUR PERSONAL RECORDS AND WILL NOT BE FOR PUBLIC VIEW.

PATIENT SIGNATURE ____DATE____________________________

WITNESS SIGNATURE ____DATE____________________________