APPLICATION FOR FREE AND REDUCED-CHARGE SERVICES
UNDER THE INDIGENT CARE TRUST FUND (ICTF) PROGRAM
Wills Memorial Hospital

Patient's Full Name: _____ Patient's Date of Birth: _____

Date/s of Service: _____ Amount of Charges: $_____

Applicant's Full Name: _____ Relationship to Patient: _____

Applicant's Mailing Address: _____

Applicant's Telephone/s: (home)_____ (mobile)_____ (work)_____

Applicant's E-Mail Address: _____

List members of household, birthdate, relationship to patient, and income from each source: state whether income is per week, month, or year.

FULL NAME	BIRTHDATE	RELATIONSHIP	INCOME (WK/MO/YR)	INCOME (WK/MO/YR)	TOTAL INCOME

If the income on any member is from self-employment, you may give information on costs so that we can determine the actual income to be counted. Document details on the back of this page.

(**Note to Applicant:** You do not have to report income for a person in the household who is not legally responsible for the patient's medical bills and is not counted in the family size. For example, if you have a brother or sister who lives with you, that person is not responsible for paying your medical bills and would not have to be counted or report income.)

Signature of Applicant: _____ Date: _____

For Hospital Staff Use:

(Average monthly income for last year or past three months, whichever is more favorable.)

NUMBER COUNTED IN HOUSEHOLD: _____ TOTAL COUNTABLE INCOME: _____

Determination: Eligible for free services_____ Conditional? _____ Pending: _____

Eligible for discount _____% Conditional? _____ Pending: _____

Ineligible: _____ Reason: _____

Date notice mailed: _____ Staff Signature: _____ Date: _____

Reconsideration: Result: _____ Date: _____

Page 1 Financial Assistance Worksheet

Patient Information:

Full Name:	
Social Security #:	
Date of Birth:	
Address:	
Phone Number:	Home: _____ Mobile: _____ Work: _____
Employer Name and Address:	
Employment Status:	*Check one:* Full-time___ Part-time___ Retire___ Not Applicable____
Spouse's Full Name:	
Spouse's Social Security #:	
Spouse's Date of Birth:	
Spouse's Employer Name and Address:	
Spouse's Employment Status:	*Check one:* Full-time___ Part-time___ Retire___ Not Applicable____

Monthly Expenses	***Amount***
Rent/Mortgage	
Auto	
Utilities	
Phone	
Other: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	
TOTAL EXPENSES	

Savings Account Amount and Location	
Checking Account Amount and Location	
Savings Bonds and Location	
CD Amount and Location	
Retirement Funds	
Life Insurance Face Value	
Rental Property	
Other Assets	
TOTAL ASSETS	

Patient/Guarantor Signature: _____ Date: _____