

**COMMUNITY CARE APPLICATION FOR HAYWARD AREA MEMORIAL HOSPITAL**

- 1. ID#: \_\_\_\_\_
- 2. Date of Request: \_\_\_\_\_
- 3. Requestor's name : \_\_\_\_\_  
Patient's name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Single \_\_\_ Married \_\_\_

4. Address: \_\_\_\_\_ Phone: \_\_\_\_\_

- 5. Number of persons in Family \_\_\_\_\_  
Names of Dependents responsible for (as claimed on Income Tax return)  

<u>Names</u>	<u>Relationship</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- 6. Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Length of Employment: \_\_\_\_\_ Position: \_\_\_\_\_  
Salary: Before Deductions \$ \_\_\_\_\_ After Deductions \$ \_\_\_\_\_  
Basis of Pay: Hourly \_\_\_\_\_ Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly \_\_\_\_\_

- 7. Spouse's Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Length of Employment: \_\_\_\_\_ Position: \_\_\_\_\_  
Salary: Before Deductions \$ \_\_\_\_\_ After Deductions \$ \_\_\_\_\_

- 8. Other Income: Social Security: \_\_\_\_\_  
Welfare: \_\_\_\_\_ Railroad Retirement: \_\_\_\_\_  
Workers Compensation: \_\_\_\_\_ Veterans: \_\_\_\_\_  
Unemployment: \_\_\_\_\_ Pension: \_\_\_\_\_

Assets:

9. Checking: \_\_\_\_\_

10. Savings: \_\_\_\_\_

Auto:            Make: \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_

Auto:            Make: \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_

11. FAMILY INCOME LAST TWELVE (12) MONTHS: \$ \_\_\_\_\_

12. FAMILY INCOME LAST THREE (3) MONTHS: \$ \_\_\_\_\_

13. \_\_\_\_\_ If you are seeking charity for services already rendered by the Hayward Area Memorial Hospital, list dates of service:

\_\_\_\_\_

14. \_\_\_\_\_ If you are seeking an eligibility determination for services not rendered, list expected dates of service:

\_\_\_\_\_

Copies of W-2's, Payroll stubs, Income Tax Forms, etc. must be attached to substantiate income.

#### STATEMENT

I hereby request that Hayward Area Memorial Hospital provide community care services to me, or my family member mentioned, at a reduced charge as may be determined by the hospital. In requesting these services I represent, under oath, that I am unable to pay for the health services requested, and that all of the information supplied by me is true and correct. I understand that the information which I submit to the Hayward Area Memorial Hospital is subject to verification. You are authorized to check my credit and employment history given on this application.

\_\_\_\_\_  
Applicant signature