WEIRTON MEDICAL CENTER

Date of Application___________________________________ Referred By____________________________

Patient (s) Name: _____________________________________ / ____

Mailing Address: ____

MR # (s) ______________ /________________ Initial Acct # (s) ____________________ / _______________________

Soc Sec # (s) ______________________ /________________________ DOB (s) ______________ /_______________

Daytime Phone _____________________________________ Cell Phone _____________________________________

Marital Status: Married Single Divorced Separated Widowed

Employed: Yes______ No______ Number of Dependents Claimed: __________

Employer:____ Position: __________________________

Address:____

Spouse Employer:_____________________________________ Position: __________________________

Address:____

Checking, Savings or Other accounts (IRA, 401K, Certificates of Deposit, Mutual Funds and Money Markets)

Type	**Name of Bank**	**Acct #**	**Current Balance**
_________	_____________________________________	_________________	______________________
_________	_____________________________________	_________________	______________________
_________	_____________________________________	_________________	______________________
_________	_____________________________________	_________________	______________________

Authorization and Verification

I,______________________________ /____________________________, hereby verify that the information provided for this form is true and correct to the best of my knowledge. I authorize Weirton Medical Center to make any investigation necessary to verify my eligibility for Charity Care with my account including, but not limited to, credit rating inquiry to credit agencies. **In the event there would be a change in income, address employment, change in insurance, or any other circumstance that could affect this charity care application, I am required to notify Weirton Medical Center within 30 days.** I understand that falsification of this information may result in a denial of any assistance and my being solely responsible for the full charges for the services provided. I further understand that my eligibility for Charity Care may be reevaluated for each hospital service.

Date:________________ Patient ______________________________________

Patient______________________________________

Name of Representative________________________

Relationship to Patient_________________________

OFFICE USE ONLY

APPROVED: YES NO

CHARITY CARE PERIOD:________________ EFFECTIVE DATES_______________________

Financial Counselor Signature :____________________________________Date:____________

Manager Signature: ____Date:____________

Card # ___________