

MASON DISTRICT HOSPITAL CHARITY APPLICATION

Information Applicant			
Name (Last, First, Middle Initial)	Age	Marital Status	Name of Spouse
Address (Street, City, State, Zip)	How Long	County	Home Phone Number () -
Name and ages of children living at home or other dependents living with you			
Name and Address of Nearest Relative not living with you (Include Street, city, State and Phone)			
Employment and Salaries			
List all employment information of all members of your family that work or have worked in the last 12 months. Begin with your most current employment. Provide copies of wage statements or W-2's			
Name of Employed Person	Name and Address of Company	Dates From To	Salary Gross/Wk./Month
Other Income: (Include pension, annuities, working dependents, Income from Family or Friends, etc. and describe):			

Federal Or State Program/Support – Provide proof of income

Unemployment Yes No If yes \$ _____ Monthly Name of person receiving this benefit: _____

Public Aid Yes No If Yes \$ _____ Monthly, Case

If No provide copy of denial letter from Public Aid

Name _____

Food Stamps Yes No If Yes \$ _____ Monthly, Case

Name _____

Social Security Yes No If Yes \$ _____ Monthly,

Name _____

Disability Yes No If Yes \$ _____ Monthly,

Name _____

Child Support Yes No If Yes \$ _____ Monthly,

Name _____

Real Estate and Asset Information

Are you buying your home? Yes No If yes Name of Lending

Institution _____

Mortgage Amount \$ _____ Approx. Value _____

Do you have any acreage or income producing property? Yes No If Yes list the location _____

Type of property _____

Mortgage Amount \$ _____ Approx. Value _____

Other Assets: Description (Name of Bank) Acct #

Amount/Value

Checking Account Yes No _____

\$ _____

Savings Account Yes No _____

\$ _____

Savings Bonds Yes No _____

\$ _____

Stocks, Bonds, IRA Yes No _____

\$ _____

Other Yes No _____

\$ _____

Do you own or are you buying an automobile(s)? Yes No If Yes, please list them below:

Owner _____

Make _____ Model _____ Year _____

Value \$ _____ Payment per month \$ _____

Owner _____

Make _____ Model _____ Year _____

Value \$ _____ Payment per month \$ _____

Expenses Monthly (provide copies of bills)				
Housing \$ _____ Food \$ _____ Cable \$ _____ Trash \$ _____ Other \$ _____		Utilities \$ _____ Water \$ _____ Telephone \$ _____ Clothing \$ _____ Total \$ _____		
Debts				
Name of Company	Description of Debt	Unpaid Balance	Expected monthly payment	Actual Monthly payment
Medical Expenses				
Owed to	Original Bill	Unpaid Balance	Expected Monthly payment	Actual Monthly Payments
Insurance Expenses				
Company name	Type of insurance	Monthly Payment	Cash value if any	Length of payment

Signature of Applicant:

By signing my name to this form I am stating that the answers I have given are true and complete to the best of my knowledge. I also understand that this application shall remain the confidential property of Mason District Hospital. I hereby give my consent to Mason District Hospital to make inquiries concerning the information in this application.

Applicant's Signature

Date