REQUEST FOR WE-CARE PROGRAM

Applicant's Name & Address

_____

_____

_____

_____

_____

Dependents Name	Date of Birth	Social Security #

Phone #:_____

Social Security #:_____

Proof of Income Received:

☐ W-2 ☐ SS

☐ Tax Return ☐ Pay Stub

☐ Other

Total Household Income: $_____

Yearly Estimated Income: $_____

I understand that this application is made so that IRMC Physician Group can determine my eligibility for uncompensated service under the We-Care Program, based on the established criteria on file in the office of IRMC Physician Group located at 640 Kolter Dr Indiana PA 15701. If any information I have given proves to be false, I understand that IRMC PG may re-evaluate my financial status and take whatever action becomes appropriate.

I understand that it is MY responsibility to notify IRMC PG of any changes, and to update my application every SIX (6) months unless otherwise stated.

I have read and understand the WE-Care policy and a copy has been provided for me.
I certify that the above information is true and accurate as to the best of my knowledge.

SIGNATURE OF APPLICANT:_____ DATE: _____

For IRMC PG ONLY below this line

Total household income should not exceed $_____ based on family size of _____.

Category: _____
Patient Responsibility: $_____

Date of Request: _____
Date Received at IHPS: _____
Approval/Denial Date: _____
Denial Reason: _____
Expiration Date: _____

EMPLOYEES SIGNATURE: _____ DATE: _____