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 uncompensated service under the We-Care Program IRMC Physician Group located at 640 Kolter Elbe false, I understand that IRMC PG may re-evappropriate.	gram, based on the establ Dr Indiana PA 15701. If a	ished criteria on ny information I	file in the office of have given proves t
I understand that it is MY responsibility to rapplication every SIX (6) months unless other		changes, and to	update my
I have read and understand the WE-O I certify that the above information			
SIGNATURE OF APPLICANT:		DATE:	
For IRMC PG ONLY below this line			
Total household income should not exceed \$	based on fa	mily size of	·
Category: Patient Responsibility: \$			
Date of Request: Date Received at IHPS: Approval/Denial Date: Denial Reason: Expiration Date:			
EMPLOYEES SIGNATURE:	- DA	TE:	