Doylestown Health
Doylestown Hospital

Financial Assistance Application

Account # _____

Patient Name: _____

Thank you for your interest in Doylestown Hospital's Financial Assistance Program offered by Doylestown Health. Please provide documentation which reflects your household gross income.

Family size - All persons living in the same household, including parent(s) and all dependents. (as defined by the IRS)_____

___ 3 recent pay stubs from employment.
___ 3 recent bank statements checking and/or savings.
___ A copy of your most recent tax return.
___ A copy of the letter stating unemployment or disability benefits.
___ Self-employment business bank statements and copy of Profit and Loss.
___ A current copy of social security benefit payment notification.
___ Pension benefits
___ Alimony
___ Other Income

If all documents are not received with the application, determination could be delayed or denied.

If you have any questions, please contact our Patient Billing & Financial Services Office at 215-345-2198.

SIGNATURE _____
Above information is true, complete, and correct to the best of my knowledge

DATE SIGNED _____