HNB The Honesdale National Bank

# C.E. Gibbs Memorial Fund Application

| First Name | | Middle Initial | Last Name | |
|---|---|---|---|---|
| | | | | |

| Street Address | City | State | Zip Code | County of Residence |
|---|---|---|---|---|
| | | | | |

| Email | Phone Number |
|---|---|
| | |

| Number of People Living in the Household | Employment Status | Employer | Total Taxable Income |
|---|---|---|---|
| | | | |

| Total Estimated Cost of Medical Need | Hospital/Medical Facility | Phone Number |
|---|---|---|
| | | |

| Do you have health insurance? If so, which? | Have you applied for any other medical assistance? If so, please provide the name. | Have you contacted provider for discounts? If so, was there a discount provided? |
|---|---|---|
| | | |

| What is your estimated monthly income? | Individually list your monthly expenses and the approximate amount for each (rent, credit cards, utilities, food, etc.): | Does monthly income exceed monthly expenses? |
|---|---|---|
| | | |

**Please attach copies of the following:**

- Letter explaining financial need due to a medical treatment cost
- Letter from medical professional stating need of procedure (If able)
- Latest income tax return
- Copy of medical bill or invoice

**Send filled out application and all required documents to:**

The Honesdale National Bank
c/o Trust Department
724 Main Street, PO Box 350
Honesdale, PA 18431