

FINANCIAL ASSISTANCE APPLICATION

APPLICANT INFORMATION

Name:

Date of birth:

SSN:

Phone:

Current address:

City:

State:

ZIP Code:

Cell Phone:

E-mail Address:

EMPLOYMENT INFORMATION

Please indicate if you are Employed/Retired/Disabled:

Current employer (I/A):

Employer address:

How long?

City:

State:

ZIP Code:

Position:

Annual income:

HOUSEHOLD CO-APPLICANT INFORMATION

Name:

Date of birth:

SSN:

Phone:

Current address:

City:

State:

ZIP Code:

EMPLOYMENT INFORMATION

Please indicate if the co-applicant is Employed/Retired/Disabled:

Current employer (I/A):

Employer address:

How long?

City:

State:

ZIP Code:

Position:

Annual income:

ADDITIONAL HOUSEHOLD INCOME

Name

Relationship to Applicant

Annual Income

OTHER ASSETS OR SOURCES OF INCOME - **(SEE "PROOF OF ASSETS" ON CHECKLIST)**

Description

Amount per month or value

FINANCIAL ASSISTANCE APPLICATION

ACCOUNTS RELATED TO APPLICATION REQUEST **** (FOR OFFICE USE ONLY) ****

Patient Name:	Account no.	Date of Service:	Amount:

I certify that the above information is true and accurate to the best of my knowledge. I will exhaust all other sources of assistance such as Medicaid, Medicare and/or the Exchanges which may be available for payment of my hospital related services.

I understand that this application is completed so that the hospital can determine my eligibility for uncompensated health services under the hospital's established Financial Assistance guidelines. If any of the information I have given proves to be untrue, I understand that the hospital can re-evaluate my financial status and take whatever action becomes appropriate.

Signature of applicant

Date

Signature of co-applicant, I/A

Date

ELIGIBILITY DETERMINATION (FOR OFFICE USE ONLY)

Date Received: _____

Verification Completed: Yes ____ No ____

The applicant was approved for a reduction of _____% of allowable charges. Date approved: _____

The applicant was denied for the following reason(s)

Date of Denial _____

Date Applicant Notified of Determination _____

Individual Completing Review: _____

Financial Assistance Application Checklist

Verification of the following information is needed to complete your application for Financial Assistance:

- Proof of Medical Assistance application may be required if applicable
 - **Proof of Income:**
 - Household income household income is defined as all income for individuals in the household who have a tax/taxable relationship to the patient. (File joint return or is a dependent on another individual's return) This follows the same definition guidelines as PA Medicaid.
 - Income Tax Return (if applying in first three months of calendar year)
 - Pay Stubs and/or Unemployment Compensation Income statements for the past three months (for applications April through December)
 - Unemployment Compensation
 - Social Security verification
 - Pension
 - Workers Compensation
 - Sick Benefits
 - Self-Employment
 - Rental Income
 - Child Support
 - Interest or Dividends
 - Any other income into the household
 - MA162 with income information
 - Payments from personal insurance policies that provide additional income or payment to defray medical related incident costs.
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 - **Proof of Assets: **** (Balance over \$10,000/person or \$15,000/couple not qualified for Financial Assistance. Please proceed with application to apply for extended payment plan) ******
 - Checking Account – most recent statement
 - Savings Account – most recent statement
 - Certificate of Deposit (CD)
 - US Savings Bond
 - Stocks or Bonds
 - HRA, HSA, FSA, or any medical savings or reimbursement account

Disclaimer Points:

1. You must apply within 240 days from date of self-pay balance or application will be denied.
2. Any material misrepresentations will result in the reversal of approved applications, and denial of open applications. Any related reductions will be reversed and the applicant will be barred from participation for a period of 3 years.
3. Services considered to be personal and/or cosmetic will not qualify for Financial Assistance.
4. Medical savings, reimbursement and all other similar accounts must be depleted prior to providing any type of financial assistance
5. A PA Medical Assistance denial may be required before Financial Assistance eligibility can be determined.

