FINANCIAL ASSISTANCE APPLICATION

APPLICANT INFORMATION		
Name:		
Date of birth:		**Phone:**
Current address:		
City:	**State:**	**ZIP Code:**
Cell Phone:	E-mail Address:	

EMPLOYMENT INFORMATION		
OPTIONAL: Please indicate if you are Employed/Retired		
Current employer (I/A):		
Employer address:		
City:	State:	ZIP Code:
Position:	**Annual income:**	

HOUSEHOLD CO-APPLICANT INFORMATION		
Name:		
Date of birth:		Phone:
Current address:		
City:	State:	ZIP Code:

EMPLOYMENT INFORMATION		
OPTIONAL: Please indicate if the co-applicant is Employed/Retired		
Current employer (I/A):		
Employer address:		
City:	State:	ZIP Code:
Position:	**Annual income:**	

ADDITIONAL HOUSEHOLD MEMBERS AND INCOME, IF ANY		
Name and Age		**Annual Income**

ONLY IF INCOME >200% OF FPL. **(SEE "PROOF OF ASSETS" ON CHECKLIST)OTHER ASSETS OR SOURCES OF INCOME –**	
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. If income is above 200% of FPG, I will exhaust all other sources of medical coverage and assistance that 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: _____

PMHA/dbm/082624

Financial Assistance Application Checklist

Verification of the following applicable information is needed to complete your application for Financial Assistance. Failing to provide all the requested/required documents will cause a delay in application processing.

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 not on another individual's return) This follows the same definition guidelines as PA Medicaid.
- Most recent Income Tax return
- Pay Stubs and/or Unemployment Compensation Income statements for the past three months (for applications April through December)
- Unemployment Compensation
- Social Security income 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.
- Current Photo ID (Driver's license, State issued ID, Work Visa)

- ***<u>Proof of Assets does not apply to applicants at or below 200% of the current Federal Poverty Level.</u>***
- **Proof of Assets: **(Balance over $10,000/person or $15,000/couple not qualified for Financial Assistance.**

    - 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 the 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.

3. Services considered to be personal and/or cosmetic will not qualify for Financial Assistance.

4. Elective services provided to an individual at a facility deemed by the insurance carrier to be "out of network" or "noncontracted" will not qualify for the Financial Assistance discount unless the pt has out of network benefits in their insurance plan.

5. Medical savings, reimbursement and all other similar accounts must be depleted prior to providing any type of financial assistance

6. A PA Medical Assistance denial *may* be required before Financial Assistance eligibility can be determined.

PMHA/dbm/082624