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

ACCOUNTS RELATED TO APPLICATION REQUEST			
Patient Name:	Account no.	Date of Service:	Amount:

OTHER ASSETS OR SOURCES OF INCOME	
Description	Amount per month or value

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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 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.

The applicant was denied for the following reason(s)

_____

Date of Determination: _____ Date Applicant Notified: _____

Individual Completing Review: _____

Form# FIN-3372-LV
Orig 09/14

ACMH

Financial Assistance Application Check List

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 guidelines as PA Medicaid definition.
        - 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.
    - Proof of Assets
        - Checking Account – most recent statement
        - Savings Account – most recent statement
        - Certificate of Deposit (CD)
        - US Savings Bond
        - Stocks or Bonds
        - HRA, HAS, FSA, or any medical savings 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