FINANCIAL ASSISTANCE APPLICATION

PATIENT OR APPLICANT NAME: _____

ADDRESS: _____

CITY: _____STATE: _____ZIP:_____

DATE OF SERVICE: _____
ACCOUNT NUMBER: _____
CSN: _____
HOSPITAL: _____

THE FOLLOWING <u>MUST</u> BE COMPLETED FOR FINANCIAL ASSISTANCE CONSIDERATION. PLEASE NOTE UNINSURED PATIENTS MUST PARTICIPATE WITH OUR INSURANCE ELIGIBILITY VENDOR PRIOR TO RECEIVING ASSISTANCE. DECISIONS WILL BE RENDERED WITHIN 90 DAYS OF RECIEPT OF COMPLETED APPLICATION AND PARTICIPATION WITH OUR VENDOR

NAME	RELATIONSHIP TO PATIENT	AGE	TOTAL INCOME IN THE 3 MONTHS PRIOR TO THE DATE OF SERVICE	TOTAL GROSS INCOME IN THE PRIOR 12 MONTHS PRIOR TO DATE OF SERVICE	SOURCE OF INCOME EMPLOYER NAME (STATE IF YOU ARE A COLLEGE STUDENT
	SELF				

1. **IF YOU REPORTED ZERO TOTAL INCOME, HOW ARE YOU BEING SUPPORTED? _____**
2. WHAT STATE DID YOU RESIDE IN AT THE TIME OF YOUR VISIT? _____
3. HAVE YOU APPLIED FOR MEDICAID OR ANY OTHER COUNTY ASSISTANCE? ☐ NO ☐ YES (DATE/STATE_____)
4. DID YOU HAVE HEALTH INSURANCE ON THE DATE OF SERVICE? ☐ NO ☐ YES (PROVIDE COPY OF CARD WITH THIS APPLICATION)
5. WAS THE DATE OF SERVICE RELATED TO AN AUTO ACCIDENT? ☐ NO ☐ YES (INSURANCE NAME/CLAIM#_____)
6. DOES ANYONE IN YOUR HOME HAVE A CHECKING OR SAVINGS? ☐ NO ☐ YES (VALUE_____)
7. DOES ANYONE IN YOUR HOME HAVE ANY OTHER ASSETS? ☐ NO ☐ YES (TYPE/VALUE)_____)
8. DO YOU OWN OR RENT A HOME? ☐ OWN ☐ RENT ☐ OTHER (_____)

FOR INCOME ASSETS LISTED ABOVE YOU MUST PROVIDE THE FOLLOWING FOR EACH MEMBER OF THE HOUSEHOLD:

(please check items received)

- ☐ EMPLOYMENT = 3 OR 12 MONTH INCOME
- ☐ UNEMPLOYMENT = BENEFIT LETTER
- ☐ SOCIAL SECURITY = BENEFIT LETTER
- ☐ PENSION OR DISABILITY= BENEFIT LETTER
- ☐ SELF EMPLOYMENT = COMPLETE TAX FORMS INCLUDING SCHEDULE C
- ☐ CHILD SUPPORT = COURT ORDERED DOCUMENT
- ☐ OTHER= PROOF OF ANY OTHER INCOME SUCH AS DIVIDENDS, INTEREST, RENTAL INCOME
- ☐ CHECKING / SAVINGS = CURRENT 30 DAY STATEMENT FOR EACH ACCOUNT

CERTIFICATION: *BY SIGNING THIS DOCUMENT, I AFFIRM THE ANSWERS ON THIS APPLICATION ARE TRUE. SHOULD A SUBSEQUENT REVIEW OF AN INDIVIDUAL'S FINANCIAL ASSISTANCE APPLICATION REVEAL THAT INFORMATION PROVIDED BY THE INDIVIDUAL WAS EITHER INCORRECT OR FRAUDULENT, THE DECISION TO PROVIDE FINANCIAL ASSISTANCE MAY BE REVERSED AND THE RESPONSIBLE PARTY WILL BE BILLED. I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT IS SUBJECT TO VERIFICATION BY MY HOSPITAL PROVIDER, INCLUDING CREDIT REPORTING AGENCIES, AND SUBJECT TO REVIEW BY FEDERAL AND/OR STATE AGENCIES AND OTHERS AS REQUIRED.*

PATIENT SIGNATURE: _____ DATE: _____

APPLICANT OR REPRESENTATIVE SIGNATURE:_____RELATIONSHIP:_____DATE:_____
(IF NOT PATIENT)

MAIL COMPLETED APPLICATION AND DOCUMENTATION TO:
1605 Valley Center Parkway, Suite 180
Bethlehem, PA 18017

Last Revision: 12/2019