Name of Hospital
Address
For assistance in completing application, contact the Patient Financial Counselor at Phone Number

Financial Assistance Application

(Hospital Name) will grant financial assistance to qualified patients on the self-pay portions of their accounts as long as resources are available to finance such care.

In order to receive financial assistance the application must meet the following eligibility requirements:

1. Care rendered **must not** be for experimental, cosmetic, or elective reasons and must be medically appropriate;

2. The applicant's financial situation is consistent with the provision of charity care;

   - ✓ Assets are those necessary for the patient's daily living
   - ✓ Income does not exceed the amount needed to meet patient's daily living expenses; and

3. The applicant is **not** eligible for federal or state assistance (Medicaid, Chips, VA); or

4. There is no other source of payment for the patient's medical bill; for example, medical insurance coverage; and

5. Bad Debt Accounts are **not** eligible for financial assistance (Charity Care).

6. For patients who have multiple visits yearly, an application will be required every six months to ensure all information is accurate.

7. Medicaid Spin Down will **not** be eligible for financial assistance (Charity Care).

ATTACHMENTS:

All applicants must attach the copies of the following. **Incomplete applications will be denied.**

1. Federal or State tax returns for last year and, or

2. Copy of most recent social security related income amount if applicable, or

3. Pay stubs for three (3) month for all family unit members who are employed, and

4. Proof of any other source of income.

5. All bank statements for three (3) months, and

6. Copy of denial letter from Medicaid.

7. Any other information deemed necessary by (Hospital Name)

   - ✓ Proof of no income for family unity members as applicable
   - ✓ Proof of monthly pharmacy expenses
   - ✓ Proof of expenses, assets, liabilities as described, if applicable

FOR HOSPITAL USE ONLY
FINANCIAL COUNSELOR SUBMITTING APPLICATION: _____DATE:_____ FINANCIAL COUNSELOR ACCEPTING APPLICATION: _____DATE:_____ APPROVED: _____ Expiration Date: _____ REJECTED: _____ VALID 6 MO FROM APPROVAL DATE) INCOMPLETE: _____
****Does the applicant appear to qualify for CHIPS or Medicaid? If yes, refer to appropriate agency. FS Clerk Name: _____Date:_____
Approved By:_____Date:_____ Remarks:_____ *Application must be approved by Director of Patient Financial Services or Authorized Personnel*

Name of Hospital
Address
Attention: Patient Financial Services

FINANCIAL ASSISTANCE APPLICATION

( ) Financial Assistance – (Hospital Name) Services
( ) Financial Assistance – (Hospital Name) Medical Clinic Services

Today's Date: _____

Please answer all questions completely and to the best of your knowledge in order to prevent delaying this application. Copies of income, countable resource and expenses MUST be attached or application will be rejected as incomplete.
IF ALL AREAS ARE NOT COMPLETED, THE APPLICATION WILL BE REJECTED.

Patient Name: _____Phone #:_____

Address (including directions: if PO Box include route number):

_____

_____

Age: _____ Marital Status: _____ West Virginia Resident (Y/N): _____

County of residency: _____

Account Number	Amount
	$
	$
	$
	$
	$
	$
	$
	$
Total Financial Assistance Request	$

Section 1 – Household & Employment Information

List all persons living in household.

NAME	RELATIONSHIP / AGE	INSURANCE COVERAGE

Was this visit to the hospital in any way related to an on-the-job injury or occupational disease? _____

If yes, please explain_____
_____

Are you presently employed: Patient:_____ Part Time:_____ Full Time:_____
Spouse:_____ Part Time:_____ Full Time:_____

Patient's current employer: _____
Employer Address : _____
Phone: _____Length of employment_____
Spouse's current employer: _____
Employer Address : _____
Phone: _____Length of employment_____

If unemployed, list past employment:

	Patient's	Spouse's
Employer:	_____	_____
Address:	_____	_____
	_____	_____
Phone:	_____	_____
Date last employed:	_____	_____

Section 2 – Monthly Household Income & Expenses

Household Monthly Income SUPPLY COPIES OF SUPPORTING DOCUMENTS			
Wages:	$	Food Stamps:	$
Tips:	$	Retirement:	$
Alimony/Child Support:	$	Unemployment:	$
Social Security:	$	General Relief	$
Pensions:	$	Strike Benefits	$
Military Family Allotments:	$	Income from Dividends:	$
Income from Interest:	$	Income from Rent:	$
Income Other: (explain)	$		
Total Income:	$		

Household Monthly Expenses SUPPLY COPIES OF SUPORTING DOCUMENTS	
Description	**Monthly Amount**
House Rental / Payment	
Food	
Car Payment	
Car Operating Expenses	
Phone	
Electric	
Gas	
Water	
Sewer	
Other Medical	
Other (Specify)	
Total Expenses	

Section 3 – Assets & Liabilities

Assets (Value)		**Liabilities (Balance Owed)**	
House / Land Value	$	Automobile Loan	$
Name and Address of Bank	$	Vehicle #1 Vehicle #2 House/Real Estate Loan	$
Savings Account Amount	$	Personal Property Loans	$
Checking Account Amount	$	Life Ins. Loans	$

Stocks/Bonds/CDs/IRAs	$	Credit Card Balances	$
Guns/Jewelry over $500.00	$	Medical Liability	$
Retirement Funds/Pensions	$	Taxes Due on Real Estate	$
Cash Value of Life Insurance	$	Other Installment Loans	$
Other Assets (Specify)	$	Other Liabilities (Specify)	$
Other Assets (Specify)	$	Other Liabilities (Specify)	$
Other Assets (Specify)	$	Other Liabilities (Specify)	$
Total Assets	**$**	**Total Liabilities**	**$**

Section 4 – Applicant Other Than Patient

If applicant is deceased, please complete the following:

1. Date patient expired _____/_____/_____
2. Is there a surviving spouse? (Y/N) _____. If yes, name and address of surviving spouse:

   _____

   _____
3. Is there an estate? (Y/N) _____
4. How was this verified? _____
5. Name of persons making application: _____
6. Relationship to patient: _____

Applicant Signature Date

Section 5 – Authorization and Certification

Patient Name:

Poverty Level: Based on Income level
Qualifies at

Family Size
Income (Monthly)

Debt/Income: D/I Ratio

Monthly Income
Monthly Expenses

Net Worth:

Net Worth ($)

Liabilities (Balance Owed)
Assets (Value)

The Poverty level, Debt to Income and the net worth of the patient was reviewed and based on the hospital guidelines this application has been:

APPROVED: ☐ _____ % of approval

DENIED: ☐

State of West Virginia
County of _____ to Wit:

I swear that the above information is correct and complete. Further, I will make an application for any assistance (Medicaid, Medicare, Insurance, etc), which may be available for payment of my charges. I will take any action reasonable necessary to obtain such assistance and will assign or pay to (Hospital Name) the amount recovered for (Hospital Name) charges. I authorize (Hospital Name) to contact the employers and institutions on this application to verify its accuracy. I further authorize the employer/institutions to release such information to (Hospital Name).

_____ _____
Patient/Applicant Signature **Date**

Completed By:

_____ _____
Financial Counselor **Date**

Hospital Specific Decision

Taken, subscribed and sworn to before me on this _____day of _____, 20_____, by _____, Notary Public.

My commission expires:

_____

Notary Signature

_____

Date