

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

| 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

| 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: _____

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, 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.
- IF EMPLOYED: pay stubs for most recent three months.
- IF SELF EMPLOYED: Most recent Income Tax return (for applications January through June). Most recent three months of bank statements – checking and savings accounts.
- IF UNEMPLOYED: Pay Stubs and/or Unemployment Compensation Income statements for the most recent three months, most recent three months of bank statements – checking and savings accounts. If no income and living with someone else, Attestation of Provided Support required. (See Form included)
- Social Security income verification (plus most recent three months bank statements)
- Pension
- Workers Compensation
- Sick Benefits
- 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)

- **Proof of Assets does not apply to applicants at or below 200% of the current Federal Poverty Level.**
- **Proof of Assets: ** (Balance over \$10,000/person or \$15,000/couple not qualified for Financial Assistance.**
 - Checking Account – most recent statements
 - Savings Account – most recent statements
 - Certificate of Deposit (CD)
 - US Savings Bond
 - Stocks or Bonds
 - HRA, HSA, FSA, or any medical savings or reimbursement account

Stipulations:

1. Patients with self-pay balances can apply at any time. If approved, discount can be applied to any accounts 240 days old from date of approval.
2. Any material misrepresentations will result in the reversal of approved applications, and denial of open applications. Any related reductions will be reversed.
3. Noncovered: For medically necessary services, Financial Assistance covers patient liability after insurance such as deductible, coinsurance and copays assigned by an insurance plan. It does not cover services deemed to be “noncovered” by an insurance plan, “unauthorized” services, or services exceeding a benefit plan allowance. Services considered to be personal and/or cosmetic will not qualify for Financial Assistance. Dental O.R. procedures, Specialty Lenses, and DME (Durable Medical Equipment) are not covered under the Financial Assistance Program.
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. If the applicant has insurance, patient must follow the terms of the insurance plan, including use of an in-network facility. Financial Assistance cannot be used as a substitute or secondary to an out of network insurance plan in lieu of following the terms of the primary plan.
5. Medical savings, reimbursement and all other similar accounts must be depleted prior to approved discount being applied to accounts.
6. A PA Medical Assistance denial **may** be required before Financial Assistance eligibility can be determined.

7. Applications and supporting documents at one Mountains Health facility (ACMH, IRMC, PAH) may be shared with other Mountains Health facilities for verification and auditing purposes.
8. A new Financial Assistance application will not be accepted prior to the expiration of a previously approved application period.
9. Hospitals are reimbursed for financial assistance primarily through government subsidies, specifically federal and state Medicaid and Medicare Disproportionate Share Hospital (DSH) payments.



ATTESTATION OF PROVIDED SUPPORT

I, _____, have been providing support for living expenses on behalf of _____ since _____.
(Name of applicant)

- I claim _____ as a dependent on my income tax return.
I do not claim _____ as a dependent on my income tax return.
I give him/her \$ _____ in cash per month.
I give him/her no additional cash support per month.

Name Relationship to Applicant

Address

Phone No. Date