PUNXSUTAWNEY AREA HOSPITAL

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 :		
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:		
Employer address:		How long?
City:	State:	ZIP Code:
Position:	Annual income:	

ADDITIONAL HOUSEHOLD MEMBERS

Name	Relationship to Applicant	Annual Income if applicable

ACCOUNTS RELATED TO APPLICATION REQUEST

Patient Name:	Account no.	Date of Service:	Amount:

PUNXSUTAWNEY AREA HOSPITAL

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

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: ____

PUNXSUTAWNEY
AREA HOSPITAL

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
        - Income Tax Return (if applying in first three months of calendar year)
        - Pay Stubs for one month (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
    - Proof of Assets
        - Checking Account balance
        - Savings Account balance
        - Certificate of Deposit (CD)
        - US Savings Bond
        - Stocks or Bonds
        - HRA, HAS, FSA, or any medical savings account

PUNXSUTAWNEY AREA HOSPITAL

Financial Assistance Guidelines:

Household size includes:

Guarantor that is not claimed on another individual's income tax

Child over 18

Disabled over 18

Emancipated Minor

Dependents defined as:

Applicant/Co-applicant – significant other at the time of the application

Child- income tax or proof of child support

Automatic Eligibility:

Patient applies for Medical Assistance and their patient pay is less than $5,000

Scoring Results

Not Qualified:

Cosmetic Surgery

Pre-Collection Amounts

Amish and/or like contract

If any data is misrepresented

If Medical Savings Account Exists with Balance

Self-Pay balance for greater than 240 days

Medicaid denial not related to low income, i.e. incomplete application

PUNXSUTAWNEY AREA HOSPITAL

Medicaid Application

Medicaid Applications are required for high dollar encounters, i.e. Inpatients, Observation, SDC's (Same Day Outpatient Surgeries)

Accounts with no insurance until presumptive scoring is used for automated approvals of financial assistance for active accounts (non-bad debt).

Insurance deductibles of $1,000 or more

Approval Period:

Medicare eligible individual – 1 year

Non-Medicare individual - 6 months

Insurance will be deleted from demo recall based on the expiration dates.

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***

PUNXSUTAWNEY AREA HOSPITAL

Punxsutawney Area Hospital
Charity Care Income Guidelines
Effective February 1, 2021

patient's share of hospital bill	**0%**	**10%**	**20%**
family size	150% of federal poverty level	200% of federal poverty level	250% of federal poverty level
1	19,320	25,760	32,200
2	26,130	34,840	43,550
3	32,940	43,920	54,900
4	39,750	53,000	66,250
5	46,560	62,080	77,600
6	53,370	71,160	88,950
7	60,180	80,240	100,300
8	66,990	89,320	111,650
9	73,800	98,400	123,000
10	80,610	107,480	134,350
11	87,420	116,560	145,700
12	94,230	125,640	157,050

customer must have been denied coverage by Medical Assistance / Medicaid Managed Care

for customers whose income is at or below 150% of the federal poverty level 100% of the charges will be waived
for customers whose income is at or below 200% of the federal poverty level 90% of the charges will be waived
for customers whose income is at or below 250% of the federal poverty level 80% of the charges will be waived

other conditions may apply.