

APPLICATION FOR PATIENT FINANCIAL ASSISTANCE

Name: _____ Last 4 digits of Social Security #: _____ Date of Birth: _____

Current Address: _____
NUMBER & STREET CITY STATE ZIP

Home Telephone: _____ Cell Phone: _____

Previous Address if you have lived at
 Current Address less than 2 years: _____
NUMBER & STREET CITY STATE ZIP

Do you rent or own your Home? Own Rent

Are you and/or any immediate family member residing in your household currently employed? Yes No
 If YES, list the name of the person employed and his/her employer. Please remember to include yourself.

Name Employer

Name Employer

Name Employer

If YES, is medical insurance available to you through any of these employers? Yes No

Are you covered under any other person's medical insurance? Yes No

If you do not work, how long have you been unemployed? _____

Please list names of people who live in your house, their relationship, and dates of birth

Name Relationship DOB

Name Relationship DOB

Name Relationship DOB

Please attach the following for each household member. If unable to supply, please indicate the reason:

1. 1 Month of Pay Stubs:
2. Unemployment Compensation Check Stubs:
3. Income Tax return (Signed & Most Recent Year) including W-2 Withholding Statement:
4. DPA/MA Denial/Rejection: (web link for MA application: www.compass.state.pa.us)
5. Disbursement letter from Social Security Office for annual income verification.

Other Resources: Does anyone in your household have any of the following resources?

- Yes No **Savings Account.** Current balance: _____
- Yes No **Checking Account.** Current balance: _____
- Yes No **US.Savings Bonds.** Face Value: _____
- Yes No **Certificate of Deposite.** Face Value: _____
- Yes No **Trust Fund.** Current balance: _____
- Yes No **Stock or Bonds.** Current Value: _____
- Yes No **IRA, KEOGH, or Other Retirement Plan.** Current balance: _____

Patient's Gross Annual Income: \$ _____
Other Family Income: +\$ _____
Total Family Income: \$ _____

I acknowledge that the information provided is true and correct. I authorize Chestnut Hill Hospital to verify any information contained in this document for the sole purpose of assessing financial need.

I understand that if my financial situation or availability of resources changes, I am required to notify the Hospital of the change for the purpose of being reassessed for this program.

 Signature of Patient

 Date