PATIENT FINANCIAL ASSISTANCE –FINANCIAL INFORMATION SHEET (FIS)GUIDELINES

To review your account(s) for financial assistance and/or an extended payment plan, we require the completion of the enclosed Financial Information Sheets. Please note that our Financial Assistance Program (Charity Care) will **not** cover accounts that have been sent to a Credit Reporting Agency.

Application cannot be processed without proof of income for all household members and a Medicaid Denial letter for each patient seeking financial assistance. Additionally, the submitted applications must be signed.

1. COMPLETE ALL PAGES OF THE FINANCIAL INFORMATION SHEET (FIS). As the patient and/or applicant, you and your spouse must sign and date the FIS. If certain information does not apply, answer N/A.

2. All applicants must apply at the Department of Health & Human Resources for Adult and/or Children's Medicaid. A DENIAL LETTER must be submitted with this application for each person seeking financial assistance. We will not accept a denial due to failure to submit information required.

3. **Required Attachments**, **for "all" persons in your household** for the LAST 60 DAYS, include:
   a. For **employment income**, send all paycheck stubs or provide letter from employer(s) stating gross monthly income for time period listed above.
      i. If you are receiving **Social Security or disability income**, please send a copy of your letter from the Social Security Administration showing your gross income.
   b. If **Self-Employed**, please send a copy of the most current signed tax returns you filed.
   c. Proof of income for your household also includes **child/spouse support**, **unemployment payment** history, **workers' compensation payments**, **pensions**, **social security**, **TANF award letters**, **income of significant other residing in your residence**.
   d. Copy of your latest **full bank statements** for checking and savings accounts.
   e. Statement of Support - If you are living with someone who provides you with a place to live and/or pay your basic needs, this person needs to complete a "Notarized Letter of Support".

<u>Please mail your application & all documentation to:</u>

Grant Memorial Hospital, Attn: PFS – Financial Assistance Program, PO Box 1019, Petersburg, WV 26847

Once your application has been approved or denied, a determination letter will be sent to you within 15 days. (Applicants with high dollar medical bills may require extra processing time).

FINANCIAL INFORMATION SHEET (FIS)

DUE BACK BY _____

Patient Name: _____

Account Numbers

GMH: _____
Ortho: _____
PMG: _____
Surgical: _____
OB Clinic: _____

Office Use Only:

Family: _____
Income: _____
Assets: _____
Eligible: _____

A. GUARANTOR			**Co-Guarantor-Spouse**		
First Name Middle Initial Last Name			First Name Middle Initial Last Name		
Social Security#	Date of Birth	# of Dependent Children (Living in Home) & Ages	Social Security#	Date of Birth	# of Dependent Children (Living in Home) & Ages
☐ Married (legally) ☐ Separated – How Long? _____ ☐ Unmarried (Includes: single, divorced, widowed)			☐ Married (legally) ☐ Separated – How Long? _____ ☐ Unmarried (Includes: single, divorced, widowed)		
Present Address			Present Address		
How Long? Years Months			How Long? Years Months		
Phone ( )			Phone ( )		
Previous Address (If less than two years at present)			Previous Address (If less than two years at present)		
☐ Buying ☐ Own ☐ Renting ☐ Live with parents/family/friend			☐ Buying ☐ Own ☐ Renting ☐ Live with parents/family/friend		
Employer Name & Address			Employer Name & Address		
How Long	Position	Gross Mo. Income	How Long	Position	Gross Mo. Income
Other Income $	Source		Other Income $	Source	
Previous Employer (if less than 1 year at present employer)			Previous Employer (if less than 1 year at present employer)		
Phone ( )			Phone ( )		
Hire Date: Last Day at this job:			Hire Date: Last Day at this job:		
Nearest Relative not living with you Relationship:			Nearest Relative not living with you Relationship:		
Name:			Name:		
Address:			Address:		
Phone:			Phone:		

B. INCOME INFORMATION

1. Please list all "family members (including you). Family members include parents, spouse (regardless of where they are in the home), and children (natural and adoptive) under the age of eighteen (18) living in the home alone with patient.

Family Member Name		Age	Relationship to Patient	Source of Income or Employer Name	Income for 3 Months prior to Date of Service	Income for 12 Months prior to Date Of Service
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
TOTALS						

2. If you reported $0.00 income above, please provide a brief explanation of how you (or the patient) survived financially during the period requested above (how were expenses paid)? _____

_____

3. If no employment/income, what was your last day of employment (self) _____(spouse) _____

4. Are you or your spouse receiving unemployment benefits? ☐ YES ☐ NO
   a. If yes, how much per month $_____ (please enclose a copy of Benefit Payment History from Employment Commission)

5. Does your household receive any money from any place else? ☐ YES ☐ NO
   a. If yes, from where _____ and how much per month $_____
   (Enclose proof of dates listed above)

6. How many dependents/exemptions did you claim on your last year's Federal Income Tax Return (include self, spouse, children, etc)? _____ Will there be a change in the number of dependents/exemptions claimed on this year's tax return? If yes, explain the changes: _____

_____

C. INSURANCE INFORMATION

1. Do you have health insurance covering these services? ☐ YES ☐ NO

2. If yes, enter information below & attach copy of insurance card:
   Name of insurance company: _____
   Policy #: _____ Group #: _____

3. Are you eligible for COBRA? ☐ YES ☐ NO

4. Do you have Medicaid benefits? ☐ YES ☐ NO
   a. If yes, enter billing # _____ and attach a copy of your Medicaid card.

ALL INFORMATION PROVIDED IS CONFIDENTIAL

The undersigned(s) certify that all statements made herein are true and complete and to be relied upon by this facility and/or its assignee and are made to induce this facility and/or its assignee to extend credit. The undersigned(s) authorizes this facility and/or its assignee to investigate their credit, verify employment history, and release information about this facility and/or assignees credit experience with them.

Guarantor: _____ Date: _____ Co-Guarantor: _____ Date: _____

Supervisor Approval: _____ Date: _____ CFO Approval: _____ Date: _____

REMINDER: APPLICATIONS WILL NOT BE PROCESSED WITHOUT ATTACHMENTS FOR PROOF OF INCOME FOR ALL HOUSEHOLD MEMBERS, MOST RECENT BANK STATEMENTS, AND A MEDICAID DENIAL LETTER FOR EACH PATIENT SEEKING FINANCIAL ASSISTANCE FOR THE SUBMITTED SIGNED APPLICATION.