As part of our commitment to improve the health of West Virginians and the community that we serve, WVU Medicine elects to provide financial assistance to individuals who are unable to pay for healthcare services. Individuals meeting the eligibility requirements outlined in our financial assistance policy will be granted full charity care for medically necessary services performed by WVU Medicine providers.

**Application Requirements** – The following is a list of application requirements outlined in our Financial Assistance Policy. Please indicate your eligibility for each requirement below. If you do not meet these requirements, your application will be denied. If you have exceptional circumstances and would like to speak with a representative, please contact us at 855-778-2922.

1. *Service Area Requirement* - The Financial Assistance program is designed for patients residing in our immediate service area. Financial Assistance will also be considered for out of area residents who arrive in our emergency room via ambulance or air ambulance and for out of pocket expenses when the patient carries third party insurance through commercial or government sources.

❑ State and County of Residence:

❑ Primary Insurance:

❑ Date of Emergency Room visit:

1. *Medicaid (Medical Assistance) Application Requirement –* Documentation of a denied Medicaid (Medical Assistance) application dated within in the last 90 days is required for application.

Have you applied for Medicaid coverage? ❑ Yes ❑ No

If yes, what is the status? ❑ Approved ❑ Pending ❑ Denied

1. *Current Patient Requirement:* Applications will only be processed for patients with current balances (within 240 days from first billing statement), a scheduled appointment or a patient in need of financial clearance prior to obtaining an appointment.

❑ Current Balance: Service Date on Statement:

***I have balances with the following facilities (check all that apply):***

❑ WVU Hospitals/Ruby Memorial ❑ Potomac Valley Hospital ❑ Camden Clark Medical Ctr

❑ United Hospital Center ❑ St. Joseph’s Hospital ❑ Berkeley Medical Center

❑ Jefferson Medical Center ❑ Reynolds Memorial Hospital

❑ Appointment Date: Provider/Dept. Name:

❑ Services Needed:

Dept. /Provider Name:

1. *International Patients:* Only permanent residents are eligible for financial assistance. International students are not eligible for financial assistance.

Are you a U. S Citizen? ❑ Yes ❑ No

If No, do you have a permanent resident card (green card)? ❑ Yes ❑ No

Please provide the information requested and mail to the following address:

WVU Medicine

Patient Financial Services

PO Box 8031

Morgantown, WV 26506

**SECTION ONE: PATIENT INFORMATION Please** complete all information noted in this section

Medical Record Number: ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MIDDLE INITIAL

FIRST

LAST

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State of Residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: ❑ Single ❑ Married ❑ Divorced

Are you a US Citizen: ❑ Yes ❑ No If no, are you a legal resident of the United States: ❑ Yes ❑ No

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary/Spouse Employer Name: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Insurance offered through Employer:: ❑ Yes ❑ No If yes, provide cost of employee portion: ­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have health insurance (other than Medicaid) at the time of your service?❑ Yes ❑ No If yes, please provide your insurance info and a copy of your insurance card

Name of Insurance: Effective Date: ­­­\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_­

Subscriber Name: ­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID: ­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you applied for Medicaid coverage? ❑ Yes ❑ No If Yes, what is the status? ❑ Approved ❑ Pending ❑ Denied

Have you applied for coverage through the Healthcare.gov Insurance Marketplace? ❑ Yes ❑ No

**SECTION TWO: FAMILY INCOME Please** provide income for yourself, your spouse and all other household members

|  |  |  |
| --- | --- | --- |
| **Monthly Income**  **Source** | **Total Family Income for 1 month prior to date of service** | **Type of Income verification attached Proof of income is required to process your application** |
| Wages/Self Employment | $ | Copy of most recent federal tax return (or form 4506t), pay stubs for the last 30 days |
| Social Security | $ | Social Security award letter |
| Pension, Dividends, Interest, Rental Income | $ | Pension benefits letter, Dividend/Interest Statement |
| Unemployment, Workers’ Compensation | $ | Unemployment benefit letter, Workers’ Compensation benefit letter |

If you reported $0 income, please provide a brief explanation of how you (or the patient) are meeting basic living needs. Please also provide a letter of support from any individual assisting you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION THREE: MEDICAL EXPENSES** Medical expenses will be considered as an offset to income

|  |  |  |
| --- | --- | --- |
| **Medical Bill Type** | **Monthly Amount Paid** | **Verification Required** |
| Hospital and Physician Bills (Non-WVU Healthcare providers) | $ | Copies of bills |
| Prescription Drugs | $ | Pharmacy receipt print out |
| Other Medical Expenses | $ |  |

**SECTION FOUR: FAMILY INFORMATION** Please provide income for yourself and all other household members listed on your tax return

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** | **Social Security** | **Relationship** | **Date of Birth** | **Applicant** | **Employed?** |
|  |  |  |  | Yes / No | Yes / No |
|  |  |  |  | Yes / No | Yes / No |
|  |  |  |  | Yes / No | Yes / No |
|  |  |  |  | Yes / No | Yes / No |
|  |  |  |  | Yes / No | Yes / No |
|  |  |  |  | Yes / No | Yes / No |

**SECTION FIVE: ASSETS please** list all assets and their current value

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do You Have?** | **Circle Choice** | **Description** | **Total Current Value** | **Type of Verification Required** |
| Checking Accounts (total balances) | Yes / No |  |  | Most current bank statement(s) |
| Savings Accounts (total balances) | Yes / No |  |  | Most current bank statement(s) |
| CD’s/Stocks/Bonds | Yes / No |  |  | Most current investor statement(s) |
| Second Home (not your primary residence) | Yes / No |  |  | Tax assessment |
| Land | Yes / No |  |  | Tax assessment |
| Vehicles (Cars or Trucks) |  |  |  | Tax assessment |
| 1. | Yes / No |  |  |  |
| 2. | Yes / No |  |  |  |
| 3. | Yes / No |  |  |  |
| Camper/RV | Yes / No |  |  | Tax assessment |
| Other Recreational Vehicles (Boats/Motorcycles/ATVs) | Yes / No |  |  | Tax assessment |
| Other | Yes / No |  |  | Tax assessment |

Please provide any additional information about assets listed above that you would like to have included in your application:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By my signing below, I certify that everything I have stated on this application and on any attachments is true.**

Responsible Party Signature: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Use Only

❑ Approved Due Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Denied Tracking Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Return To:

WVU Medicine

Patient Financial Services

PO Box 8031

Morgantown, WV 26506

855-778-2922