FINANCIAL ASSISTANCE APPLICATION CHECKLIST

Due Date: ________________ Tracking #: ____________________

Provide copies of documents, as originals cannot be returned.

____ Provide a copy of your Medicaid decision letter (all pages) with your application or documentation from contractor that assists patient with government assistance. The letter/documentation must be dated within the last 90 days and must state reason for denial.

____ If you do not have primary insurance coverage, a copy of the print out from Marketplace (healthcare.gov or local DHHR) is required. Print out needs to state cost of your monthly premium to obtain health coverage. If premium is less than 10% of gross monthly income, premium is considered affordable and charity cannot be granted.

____ Provide a copy of your most recent 1040 Income Tax Return Form

____ If you do not file tax returns, complete the attached 4506 – T Form

____ Copies of pay stubs for the last 30 days

____ Current Social Security Award Letter

____ Pension benefits letter, Dividend / Interest Statement

____ Unemployment Benefit Letter

____ Workers Compensation Benefit Letter

____ If you have no income please have the attached letter of support filled out by the person or persons assisting you.

____ Copies of any outstanding medical bills (non WVU Medicine providers)

____ Prescription Drug List with prices from the pharmacy (Pharmacy Receipt Print-Out required)

____ Current Bank Statement for all Checking and/or Savings Accounts

____ Current Investor Statement for all CD's / Stocks / Bonds

____ Current Tax Assessment for all Assets

____ Alimony documentation

Please legibly complete the entire application. Attach the requested documentation and return it to your financial counselor at the address listed on the application.

***If you do not submit a complete Financial Assistance Application or do not include requested information by the due date, it could potentially delay the process or provide cause for denial. ***

WVUMedicine

Financial Assistance Application Form

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: ______________________________

2) *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

3) *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: ______________________________

4) *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

Financial Assistance Application Form

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

Medical Record Number: ____________________ Applicant Name: ____
LAST FIRST MIDDLE INITIAL

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	$	

WVU Medicine

Financial Assistance Application Form

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: ______________________

Return To:
WVU Medicine
Patient Financial Services
PO Box 8031
Morgantown, WV 26506
855-778-2922

Office Use Only

❑ Approved Due Date______________________________

❑ Denied Tracking Number________________________