WVU Medicine

UNITED HOSPITAL CENTER

Financial Assistance Application

Due date: _____ **Guarantor #:**_____

<u>Provide copies of documents, as originals cannot be returned</u>

_____ 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

_____ Provide a copy of your most recent federal tax return filed. If self-employed, provide quarterly tax information and a copy of the schedule C filed.

_____ Proof of other income, child support, alimony, etc.

_____ Most recent paystub showing year to date totals. If paystub does not show year to date earnings, provide 3 consecutive months of pay stubs or a signed letter from your employer of year to date earnings.

_____ Current Social Security Award Letter.

_____ Pension benefit 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 outstanding medical bills

_____ Prescription Drug List with prices from 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

_____ All applicable parties are required to sign the application.

Please legibly complete the entire application, attach the requested documentation, sign, date and return it to: United Hospital Center, 327 Medical Park Drive, Bridgeport, WV 26330.

If you do not submit a complete Financial Assistance Application or do not include requested information by the due date, that will delay the process or provide cause for denial

LETTER OF SUPPORT

I/We _____ confirm that the individual,

_____ is being provided by me/us the following: (please check all that apply)

____ Financial Support

____ Room and Board

____ Monthly Needs

____ Other :

_____

I/We certify that this information is true and correct to the best of my knowledge. I understand that United Hospital Center will maintain the confidentiality of any information in this letter and will use this information to determine qualification for participation with United Hospital Center's Patient Assistance Program.
I/We understand this does not make me/us responsible for medical bills.

Family/Friend Signature _____ Date_____

Applicant Signature _____ Date _____

The following may not be covered under the charity program: Services related to accidents where there may be third party liability; any elective services not covered by your health insurance coverage.

All claims are reviewed prior to the charity deduction being applied. If it is determined at the time that your situation has changed or fraudulent information was supplied, you may be responsible for the bill. If it is determined that your situation has changed, your account will be reviewed to determine if you are eligible for Medical Assistance.

UNITED HOSPITAL CENTER – BRIDGEPORT, WV
PATIENT FINANCIAL STATUS STATEMENT

[%] ___/___/___ - ___/___/___ From:_____

Guarantor # _____ Guarantor # _____

Acct # _____ Acct# _____

OFFICE USE ONLY

Patient Name:_____

Section 1 APPLICANT INFORMATION	**Section 1 SPOUSE/SIGNIFICANT**
Name: _____	Name: _____
Date of Birth: ___/___/___	Date of Birth: ___/___/___
Social Security Number: _____/_____/_____	Social Security Number: _____/_____/_____
Mailing Address: _____	Mailing Address: _____
_____	_____
Residence: _____	Residence: _____
_____	_____
Telephone: _____	Telephone: _____
CIRCLE ONE: M S W D	
Section 2 SOURCE OF INCOME	**Section 2 SOURCE OF INCOME**
Employer: _____	Employer: _____
Employer Address: _____	Employer Address: _____
_____	_____
Effective Date of Employment: ____/____/_____	Effective Date of Employment: ____/____/_____
Section 3 MONTHLY EARNINGS **PROOF OF INCOME MUST BE ATTACHED** **(Submit most recent paystub that shows year to date earning. If paystub does not show year to date earnings, provide three consecutive months of pay stubs. Provide all monthly income for both the applicant and spouse/significant)** Earnings from Employer: $_____ **OTHER SOURCES-SEND PROOF** Alimony/Child Support: $_____ Black Lung: $_____ Low Earnings: $_____ Retirement: $_____ SSI: $_____ Unemployment: $_____ Workers Comp $_____ Other $_____ Rental Income $_____ (Please Explain)	**Section 3 MONTHLY EARNINGS** **PROOF OF INCOME MUST BE ATTACHED** **(Submit most recent paystub that shows year to date earning. If paystub does not show year to date earnings, provide three consecutive months of pay stubs. Provide all monthly income for both the applicant and spouse/significant)** Earnings from Employer: $_____ **OTHER SOURCES-SEND PROOF** Alimony/Child Support: $_____ Black Lung: $_____ Low Earnings: $_____ Retirement: $_____ SSI: $_____ Unemployment: $_____ Workers Comp $_____ Other $_____ Rental Income $_____ (Please Explain

Section 4

Please list:

DO YOU FILE TAXES ___ yes or ___ no

If yes, must include current year tax return and all applicable schedules. If self-employed please also provide copy of schedule C.

If no please indicate reason. _____

FULL NAMES AND BIRTHDATES OF FAMILY MEMBERS CLAIMED ON FEDERAL INCOME TAXES ONLY:

_____

_____

_____

Have you applied for assistance through state programs? __Yes __ No If yes, what is the status? __Approved __Pending __ Denied. Please include copy of Medicaid denial letter.

If you have current Medicaid or chips card for any family member, please provide the recipient name and number:

_____ _____

(Recipient Name) (Recipient Number)

_____ _____

(Recipient Name) (Recipient Number)

Section 5

A copy of your most recent bank statement that shows current balance must be included.

ASSET INFORMATION

CURRENT STATEMENTS MUST BE PROVIDED

ASSET TYPE	BALANCE	BANK/COMPANY NAME	ACCOUNT NUMBER
Savings Account			
Checking Account			
Christmas/Vacation Club			
Certificate of Deposit, Money Market etc.			
Other (explain)			

Section 6

Living with Parents or Family Members __ yes or __no

If you are currently living with someone who is paying all your monthly expenses, please have them complete the enclosed Letter of Support.

EXPENSE INFORMATION

Please include copy of medical bills and prescription receipt print out

EXPENSE TYPE	MONTHLY PAYMENT	CURRENT BALANCE
Hospital Bills		
Physician Bills		
Prescription Drugs		
Other Medical Expenses		

Return to:
United Hospital Center
327 Medical Park Drive
Bridgeport, WV 26330
681-342-3100

APPLICANT ATTESTATION & DISCLOSURE INFORMATION

PLEASE READ

I attest that the information contained on this form is true and correct to the best of my knowledge. I, also, will permit authorized Associates from United Hospital Center the opportunity to contact any employer/institution/company listed on this form. I understand that United Hospital Center will maintain the confidentiality of the information placed on this form and will only use that information to ascertain my/our ability to pay for services at United Hospital Center. Furthermore, should any monetary settlement be retrieved from any source relevant to services provided at United Hospital Center said funds shall be distributed to United Hospital for payment of accounts written off as a result of this application for assistance.

Once it has been determined that you are eligible for assistance, your application may be forwarded to a Department of Human Services or EGS representative. If EGS determines that you may be eligible for Medical Assistance, EGS will contact you to determine your Medical Assistance eligibility. If you are eligible for Medical Assistance, you will not receive assistance from United Hospital Center. However, if you are not eligible for Medical Assistance, you will receive a letter and an assistance card from United Hospital Center. **If you receive a bill from the hospital, it is your responsibility to contact the hospital.**

_____ _____

Applicant Signature **Date**

_____ _____

Spouse/Significant Signature **Date**

Explanation Area: Use this area to provide additional information that may be helpful in the processing of your application. You may also utilize this area to list additional family information.

_____

_____

_____

_____