WVU Medicine WHEELING HOSPITAL | WVU Medicine HARRISON COMMUNITY HOSPITAL

# Financial Assistance Application

Today's Date: _____

**Patient Name**: _____ **Birthdate**_____
(First, Middle, Last)

**Street Address**: _____

**City**: _____**State**_____ **Zip Code**_____

**Phone Number**: (_____) _____ **Alternate Phone**: (_____) _____

Are you or your spouse a Wheeling or Harrison Community Hospital Employee? ☐ **No** ☐ **Yes**

Were you an active Medicaid recipient at the time of your service? ☐ **No** ☐ **Yes**

If yes, please indicate Medicaid ID number: _____

Were you an active recipient of Disability Assistance at the time of your service? ☐ **No** ☐ **Yes**

Did or do you have health insurance (other than Medicaid)? ☐ **No** ☐ **Yes**

If no insurance coverage, please explain: _____

Are you homeless or have you received care from a homeless clinic? ☐ **No** ☐ **Yes**

Do you participate in the Women's Infants, and Children's Program (WIC)? ☐ **No** ☐ **Yes**

Are you currently living in low/subsidized housing? ☐ **No** ☐ **Yes**

Is the guardian responsible for the patient's bill? ☐ **No** ☐ **Yes**

Patient is deceased with no known estate. ☐ **No** ☐ **Yes**

Other (please explain) _____

**Assets** Please list all total income resources for:

Savings Accounts with: _____ Current Balance: _____

Checking Accounts with: _____ Current Balance: _____

Stocks, CDs, and Dividends, etc with: _____ Current Balance: _____

**Expenses** Please list your monthly household expenses for:

Mortgage or Rent_____ Real Estate Taxes_____

Utilities _____ Food/Groceries _____

Prescriptions _____ Medical Supplies _____

Motor Vehicle Payment _____ Motor Vehicle Insurance _____

Other expenses: _____ Other expenses: _____

**Please provide the following information for all the people in your immediate family who reside in your home. Family shall include the patient(s), their spouse, and all children, natural or adoptive, under the age of eighteen (18) who live in the home.**

| First Name | Middle | Last | Relationship to patient | Date of Birth | Gross Income for last 12 months |
|---|---|---|---|---|---|
| | | | | | |
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| | | | | | |
| | | | | | |

**Total persons in family**: _____ **Total family income**: $_____

If you claim **($0)** income, please explain your means of support, additional documentation will be required (i.e. friends, family) _____

_____

I, _____, attest that the information provided in this form is true and correct to the best of my knowledge. I understand that proofs of my income and expenses will not be returned. I understand that Wheeling Hospital will verify my information and will ask for documentation to determine if I am eligible for financial assistance. I understand that if I provide false information, I may be denied financial assistance and may be responsible solely to pay my bill(s) in full. I also understand that I may not be eligible for future financial assistance.

**Patient or guarantor signature**_____ **Date**_____

**Print patient or guarantor name**_____**Date**_____

Please mail completed application and supporting documentation to:

**Wheeling Hospital**
**Business Office**
**Credit/Collections Dept.**
**1 Medical Park**
**Wheeling, WV 26003**
**Fax: (304) 243-6343**

**If you have questions please call:**

| | |
|---|---|
| **304-243-3690** | **Last Name A thru D** |
| **304-243-8837** | **Last Name E thru K** |
| **304-243-8874** | **Last Name L thru Q** |
| **304-243-3357** | **Last Name R thru Z** |

# Instructions for Financial Assistance Application

In order for Wheeling Hospital to determine financial assistance and the timely processing of your application please make sure all sections of the application are completed, signed, and all supporting documentation is provided. In the section below Wheeling Hospital has provided a checklist of items required for supporting documentation.

**"Proofs of Income"** documents:
Please attach **copies** of these documents to the application (**documents cannot be returned**):

- ☐ For wages, **copies** of pay stubs are required (for the last three months)
- ☐ For assets, **copies** of savings/checking account, stocks, bonds and CD's are required (for the last three months).
- ☐ **And any or all of the following:**
- ☐ **Copies** of federal tax forms (IRS 1040 etc.) for the past year
- ☐ For self-employment income, **copy** of full tax form with Schedule C
- ☐ For other types of income, **copies** of proofs such as:
  - Social Security 1099 award letter
  - Unemployment or Worker's Compensation award letter
  - Alimony, child/spousal support agreement
  - Rental Income
  - Veterans/disability award letter

- ☐ For patients with no income: **Letter of Support** signed and dated by the supporting person
- ☐ **Copy** of medical assistance denial (if applicable)
- ☐ Bankruptcy notices that impact dates of medical service
- ☐ Proof of residence at homeless shelter or homelessness

Please allow Wheeling Hospital up to 30 days for processing of the application. If additional information is needed Wheeling Hospital will send a letter requesting the information needed to complete the processing of the application.

Once Wheeling Hospital receives the completed and signed application along with all supporting documentation the patient/guarantor will be notified by phone or by letter of the decision for financial assistance.

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**Credit/Collections Dept.**
**1 Medical Park**
**Wheeling, WV 26003**
**Fax: (304) 243-6343**