

## FINANCIAL ASSISTANCE APPLICATION CHECKLIST

Due Date: \_\_\_\_\_ MRN: \_\_\_\_\_

\*Please provide copies of documents, as originals cannot be returned.\*

### ***ALL APPLICANTS MUST APPLY FOR MEDICAID REGARDLESS OF PRIMARY INSURANCE***

\_\_\_\_\_ 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 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

\_\_\_\_\_ 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.***

***\*\****

## 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) *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

- 2) *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.

- 3) *International Patients:* Only permanent residents, patients with working visa, or patients with a student visa (primary insurance required with student visa) are eligible for financial assistance.

Are you a U. S Citizen?  Yes  No

If No, do you have a permanent resident card (green card), working visa, or student visa?  Yes  No

Do you have primary insurance?  Yes  No

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

WVU Medicine – Princeton Community Hospital  
Financial Counseling  
PO Box 1369  
Princeton, WV 24740  
304-598-6260

# 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: ( ) \_\_\_\_\_

Date of Birth (mm/dd/yyyy) \_\_\_\_\_ 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: \_\_\_\_\_

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

**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 450Bt), 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 (Annual or Year to Date)
Other Medical Expenses	\$	Copies of bills

**SECTION FOUR: FAMILY INFORMATION** Please provide the below information 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	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)

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 – Princeton Community Hospital  
 Financial Counseling  
 PO Box 1369  
 Princeton, WV 24740  
 304-598-6260

Office Use Only	
<input type="checkbox"/> Approved	Due Date _____
<input type="checkbox"/> Denied	Case Number _____