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 – Harrison Community Hospital
Financial Counseling
951 E Market Street
Cadiz, OH 43907
304-598-6260

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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 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 (Annual or Year to Date)
Other Medical Expenses	$	Copies of bills

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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 – Harrison Community Hospital
Financial Counseling
951 E Market Street
Cadiz, OH 43907
304-598-6260

Office Use Only

❑ Approved Due Date_____

❑ Denied Case Number_____