WELLSPAN HEALTH

Financial Assistance Application

MRN:_____

Patient Name: _____ Date of Birth: _____

Home Address: _____
Street City/State Zip

Telephone Number: (H) _____ (C) _____ Best time to call? _____

Household Members – (Include only people listed on yearly tax return and/or significant other)

Name:	Relationship:	DOB:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

Monthly Gross Income Received from ALL Household Members listed above:

Wages/Salaries (before taxes): _____ Pensions/Annuities: _____

Social Security: _____ Other Disability: _____

S.S.I.: _____ Cash Assistance: _____

Unemployment Compensation: _____ WC Compensation: _____

Child Support: _____ Spousal Support: _____

Veteran's Administration (VA) benefits: _____ Rental Property: _____

Other Unearned Income (Includes Trusts, interest/dividends):_____

Household Countable Resources: Please list your available accounts and liquid assets for your household. A liquid asset is defined as cash or any type of negotiable asset that can be converted quickly and easily into cash. Do not include your home, household items, vehicles, IRA, 401 (K) accounts and other non-liquid assets.

Certificates of Deposit: _____ Stocks or Bonds: _____

Trust Fund: _____ Savings Account: _____

Checking Account(s): _____ Savings Certificate: _____

US Savings Bonds: _____ Christmas/Vacation Club: _____

Health Savings Acct (HSA)/Health Reimbursement Acct (HRA) funds: _____ Money Market/Mutual Funds: _____

Other (please explain):_____

Verification of Income and resources must accompany application (Please attach the following if applicable):

Attached:

Y N N/A	Complete Federal Tax Return (most recent year). Personal and/or business.
Y N N/A	3 current pay stubs for each working applicant.
Y N N/A	Award letters showing deposits of Social Security, other disability, pension, worker's comp, or unemployment compensation payments.
Y N N/A	3 current Checking/Savings statements showing all deposits. If self-employed – 6 current bank statements.
Y N N/A	Child/Alimony supporting documentation
Y N N/A	Documentation of other sources of income
Y N N/A	If the household has no income, letters from persons who are assisting with daily living needs, explaining the help that the persons provide.
Y N N/A	If self-employed, please provide Profit & Loss
Y N N/A	Verification of all monthly expenses for Medicare eligible applicants.

Have you applied for Medical Assistance? Y or N If yes, please attach notice

Have you applied for Affordable Care Insurance? Y or N If yes, please attach notice

I certify that the information I have provided is true and accurate. I understand that any false information or not giving complete information will void this application.

Applicant's Signature: _____ Date: _____

Approved Date: _____ Approved %: _____

Reconsideration Date: _____ Approved %: _____

Effective Date: _____

Denied Date: _____ ❑ Over Income ❑ Non-compliant

❑ Other Reason: _____

		Reconsideration Date
Patient Financial Representative: _____	Date: _____	Date: _____
Supervisor: _____	Date: _____	Date: _____
Director: _____	Date: _____	Date: _____

Important Information:

Please complete the application.

In order to process your application we do require supporting income information. Please enclose this with your application. We will work with you to assess your qualifications for the program based on information supplied to WellSpan Health. Please understand, we will not share the information you provide – this information is for qualification purposes only.

If you have any questions about completing the application or are not sure if you qualify, please contact the location checked below.

Mail application and documentation to:

❑ **WellSpan Physician Billing Services**
1803 Mount Rose Avenue
Suite B3
York, PA 17403
717-851-6395 (phone)
717-851-6904 (fax)
Monday – Thursday 8 a.m. – 4:30 p.m.
Friday 8 a.m. – 4 p.m.

❑ **WellSpan York & Gettysburg Hospitals**
Patient Administrative Services
1001 S. George St.
PO Box 15198
York, PA 17405-9988
717-851-6395 (phone)
717-851-6904 (fax)
Monday – Thursday 8 a.m. – 4:30 p.m.
Friday 8 a.m. – 4 p.m.

❑ **WellSpan Ephrata Community Hospital/ WellSpan Medical Group-Lancaster County**
Customer Service Department
169 Martin Ave
PO Box 1002
Ephrata, PA 17522-1002
717-738-6261 (phone)
717-733-6066 (fax)
Monday – Friday 8 a.m. – 4 p.m.

❑ **WellSpan Good Samaritan Hospital/ WellSpan Medical Group-Lebanon**
4th & Walnut Streets
Patient Financial Advocate 1st Fl/PAS
Lebanon, PA 17042
717-270-4881 (phone)
717-270-3788 (fax)
Monday – Friday 7:30 a.m. – 4:30 p.m.

❑ **WellSpan Philhaven**
Patient Financial Services
283 S. Butler Rd.
PO Box 550
Mt. Gretna, PA 17064
717-675-1111 (phone)
717-270-2449 (fax)
Monday – Friday 8 a.m. – 4 p.m

We want to help. Please submit your completed application promptly!

You may receive bills until we receive your completed application and supporting documents.