Financial Assistance Policy A-401

ADDENDUM D

Financial Counselors

Meadville Medical Center

Financial Assistance Offices

751 Liberty St.

1034 Grove St.

16792 Conneaut Lake Rd

Meadville, PA 16335

(814) 333-5000 Extensions: 5682, 5722, 5761

(814) 333-5550 Oncology Patients

<u>Hours of Operation:</u>

Monday: 7:00 am – 4:30 pm

Tuesday: 7:00 am – 4:30 pm

Wednesday: 7:00 am – 4:30 pm

Thursday: 7:00 am – 4:30 pm

Friday: 7:00 am – 4:30 pm

Saturday & Sunday: Closed

Holidays (Observed): Closed

MEADVILLE MEDICAL CENTER | MORE THAN A HOSPITAL

Meadville Medical Center Financial Assistance Program Application

Note: This application is for Meadville Medical Center charges only (does not include independent physician professional charges)

Please complete all questions in this section. Failure to complete this section could result in delays in evaluating eligibility for charity care.

SECTION ONE: REQUIRED QUESTIONS

Patient Information PLEASE PRINT ALL INFORMATION

Last Name________________________ First Name____________________ M.I.________

Date of Birth_________________ Patient Social Security Number_______________________

Street Address____

City/State/Zip____

Primary Phone_________________________ Secondary Phone______________________

Current Health Insurance Company Name____

Policy Number_____________________________ Group Name/Number________________

Employment status

☐ Employed (Date of hire__________) ☐ Unemployed (how long unemployed :____________)

☐ Self-Employed ☐ Student ☐ Disabled ☐ Retired ☐ Other (__________________)

Household Members

Please attach additional sheets of paper if household has more than five members.

	Name:	Relationship:	Age:	Also applying for Fin. Asst.?
1.	___________________________	_____________________	_____________	☐
2.	___________________________	_____________________	_____________	☐
3.	___________________________	_____________________	_____________	☐
4.	___________________________	_____________________	_____________	☐
5.	___________________________	_____________________	_____________	☐

Monthly Household Income

Monthly Income Source	Applicant	Spouse/Dependent	Combined Income
Employment Income			
Social Security			
Disability			
Pension			
Unemployment			
Workers Compensation			
Veterans Benefits			
Investment Income			
Rental Property Income			
Annuities Income			
Child and/or Spousal Suppt.			
Other			

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, IRAs, 401(k) accounts and other non-liquid assets.

	Applicant	Spouse/Dependent	Combined
Checking Account (90 days)			
Savings Account (90 days)			
Trust Fund			
Stocks or Bonds			
Other			

SECTION TWO: VERIFICATION OF INCOME AND COUNTABLE RESOURCES

Please attach proof of income from the past ninety (90) days and current resources to this application. Please verify all income and resources listed in Section One. If you are unable to verify some or all of your income and resources, please explain why on an attached sheet of paper. Applications will not be rejected for inability to verify income or resources provided that reasonable explanation for the inability is given. Acceptable sources of verification include, but are not limited to:

- Denial of eligibility for Medical Assistance within past 90 days, if applicable.
- Pay stubs or letters from employers, listing wages before taxes, past 90 days.
- Most recent Federal Tax Return with applicable schedules.
- Award letters or bank statements showing deposits of Social Security, other disability, pension, worker's compensation, or unemployment compensation payments.
- Award letters, court documents, or bank statements showing deposits of child or spousal support payments.
- Documentation of other sources of income.
- If the household has no income, letters from persons who are assisting with daily living needs, explaining the help that the persons provide (e.g., grocery purchases or rent and utility payments).
- Health Savings Account (HSA) and other dedicated account statements.
- Checking and Savings statements, past 90 days
- Copy of Health Insurance Card(s), if applicable.
- Copy of Driver's License.

SECTION THREE: CERTIFICATION

____ _______________

Patient Signature **Date**

Please sign and return the completed application with the items listed in Section Two to:

Meadville Medical Center, Attn: Financial Counselor, 751 Liberty Street, Meadville, PA 16335

If you have any questions or need additional assistance, please call us at 814-333-5761.