

Dear				
Deal _		_ •		

Date

Please complete the attached EVANGELICAL COMMUNITY HOSPITAL Financial Assistance Program application and return it within 45 days using the self-addressed envelope provided for your convenience. Medical Assistance requires that you apply for eligibility within 90 days from your most recent date of service (special cases may be exempt from applying for Medical Assistance). A Medical Assistance notice of approval or denial will be sent to you. Please include your Medical Assistance denial with this application. It is very important that this application be filled out completely. We at EVANGELICAL COMMUNITY HOSPITAL are committed to the care and improvement of human life. We are also committed to providing quality care that is sensitive, compassionate, promptly delivered and cost effective. Our facility provides EVANGELICAL COMMUNITY HOSPITAL Financial Assistance Program to individuals who meet the Federal Poverty guidelines and is compliant with their rules and regulations.

To enable us to make a determination, please furnish us with the following documents to prove income:

- 1. Documentation of the gross monthly income for you and for all members of your household.
- 2. Medical Assistance notice of denial. The Medical Assistance denial notice must be dated within 6 months of this application.
- 3. Copies of income tax return(s) from the last calendar year.
- 4. Copies of Social Security Eligibility Income statement(s), where applicable.
- 5. You must list all account numbers that need to be considered. If you do not have the account numbers, please list the patient's name and dates of service.
- Please attach an additional page should the financial worksheet not have enough space for your information. Upon receipt of this information, we will review all information provided to make a determination compliant with Federal regulations.

Your application cannot be considered if it is not signed and dated or if any of the requested documentation is not received. The application must be returned within **45 days** from the date of this letter. Failure to submit documentation may result in denial of your request.

If you have any questions or need assistance, please contact Lisa Earnest at 570-522-4445.



## APPLICATION FOR EVANGELICAL COMMUNITY HOSPITAL FINANCIAL ASSISTANCE PROGRAM

Date of Application			
Applicant Name			
SS#			
Address			
Address			
City			ZIP
Members of Household			
	SS# _		_ DOB
	SS# _	<del> </del>	_ DOB
	SS# _	<del> </del>	_ DOB
	SS# _		_ DOB
	SS# _		_ DOB
	SS# _		_ DOB
Patient Account(s) #/Amount	Account#		Amount
,			
		<del></del>	
		<del></del>	



INCOME (Include all household members)	Total last 3 Months	Total Last 12 Months	
Gross Wages			
Social Security Benefits			
Pension Income			
Public Assistance			
Dividend & Interest			
Rental Income			
Farm or Self Employment Income			
Unemployment Compensation			
Worker's Compensation			
Strike Benefits			
VA Benefits			
Military Family Allotments			
Alimony			
Child Support			
Other Income			
TOTAL INCOME (before taxes)			
Please provide copies of your most recent assistance notice of denial or eligibility (Mapplication). Additional information on assistance in the second seco	edical Assistance denial		
Head of Household Employer Name			
Employer Address			
Additional Employer Names			
Employer Address			
I certify that the above information is transfication herein will disqualify me or resubmitted is subject to verification.	rue and correct to the	best of my knowledge and fur	ther agree that
Patient Signa	ture	Date	
Responsible Party	Date		