Attachment E

Aria - Jefferson Health Financial Assistance Application Form & Information

Aria Jefferson Health
Financial Services Unit

Patient Name: _____ MRN: _____

Application for: ❒ Dental ❒ Medical

Patient Name: _____ Marital Status of Patient: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Head of Household Name *(if applicable*): _____ Relationship to Patient: _____

Patient Home Phone: _____ Patient Cell Phone: _____

Patient Work Phone: _____ Patient Email: _____

Please confirm the address above. Please correct if needed.

Household Members

Please provide the full name and date of birth for all members. Please include Social Security number and relationship if known.

Name *Full Name – First Name, MI, Last Name*	**Date of Birth**	**Social Security Number**	**Relationship to Applicant**	**Citizenship** Yes, No or Perm. Resident?	**Applying** Check if Yes
			SELF		❒
					❒
					❒
					❒

Relationship to Applicant should be the relationship of the Household Member to the applicant, not the Guarantor. Examples would be wife, husband, daughter, son, mother, father, step-son, step-daughter, cousin, etc.

Household Income

Please indicate if you or anyone in your household receives any of the following types of income:

❑ Wages/Salary
❑ Self-Employed
❑ Social Security
❑ Child Support
❑ Alimony
❑ Unemployment Compensation
❑ Pension
❑ Real Estate/Rental Property Income
❑ Veteran's Benefits
❑ Disability/Disability Benefits
❑ Workmen's Compensation
❑ Student I-20
❑ Other

Please provide the following information for all incomes you have indicated are received:

Household Member	**Type** *Provide Employer Name if Applicable.*	**Amount**	**Period** *Select one.*	**Start Date**	**End Date** ***(If Applicable)***
			❑Weekly ❑Monthly ❑Biweekly ❑Annually ❑Hrly # hrs/wk _____		
			❑Weekly ❑Monthly ❑Biweekly ❑Annually ❑Hrly # hrs/wk _____		
			❑Weekly ❑Monthly ❑Biweekly ❑Annually ❑Hrly # hrs/wk _____		
			❑Weekly ❑Monthly ❑Biweekly ❑Annually ❑Hrly # hrs/wk _____		

For all household income received, you must provide supporting documents in order to complete this application. (i.e., tax return, pay stubs, approval letter(s), self-employment schedules, child support statements, etc.)

❑ My household does not have any earned or unearned income.

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Financial Services Unit

Patient Name: _____ MRN: _____

Assets/Resources

Please indicate if you or anyone in your household receives any of the following resources:

❑ Checking Account(s) ❑ CD(s) ❑ Mutual Funds
❑ Savings Account(s) ❑ Annuities ❑ Other
❑ Money Market Account(s) ❑ Bonds

Please provide the following information for all incomes you have indicated are received:

Household Member	Type	Account Number	Value

For all asset(s)/resource(s) received, you must provide 3 consecutive months statements in order to complete this application.

❑ My household does not have any assets or resources to claim.

Other Information

Please answer the following questions.

Does patient have a permanent resident card for the United States? ❑ Yes ❑ No

Does this household currently have public assistance? ❑ Yes ❑ No *If yes, provide the following:*
Insurance Company Name & ID number _____

Has patient applied for public assistance in the last 12 months? ❑ Yes ❑ No
If yes, were you denied coverage ❑ Yes ❑ No
Please attach approval/denial PA-162 letter. *(Received from the PA Dept. of Welfare)*

Does patient have health insurance? Should you receive health insurance, please notify the department. Health Insurance is always primary over financial assistance. ❑ Yes ❑ No *If yes, provide the following:*
Insurance Company Name & ID number _____

Insured's Name: _____ Birthdate:_____

Please add any other information that supports your application:

_____
_____
_____

Signature

I affirm that the above information is true, complete, and correct to the best of my knowledge:

Applicant's Signature: _____ Date: _____

OR

Authorized Representative Signature: _____ Date: _____

Authorized Representative Name: _____ Relationship to Applicant: _____

Authorized Representative Phone #: _____ Cell #: _____

For Office Use Only

Aria - Jefferson Health Financial Assistance
Application Form & Information

Aria Jefferson Health
Financial Services Unit

Patient Name: _____ MRN: _____

Date Application Sent: _____ Application Received: _____ Application Date Completed: _____

Financial Counselor Name: _____ Phone Number: _____

Department: _____ Date: _____

____ Presumptive Eligibility

____ Approved Rate: A ____ B ____ C ____ D ____ E ____ F ___ G ____

Coverage Effective Date _____ Coverage Expiration Date _____

____ Disapproved Reason _____

Total Percentage Due from Patient _____

Patient Balance/Responsibility _____

Account Reg. #	**Date of Admission**	**Account Reg. #**	**Date of Admission**	**Account Reg. #**	**Date of Admission**

Aria Jefferson Health
Financial Services Unit

Patient Name: _____ MRN: _____

Household Members (continue)

Please provide the full name and date of birth for all members. Please include Social Security number and relationship if known.

Name *Full Name – First Name, MI, Last Name*	**Date of Birth**	**Social Security Number**	**Relationship to Applicant**	**Citizenship** Yes, No or Perm. Resident?	**Applying** Check if Yes
					❒
					❒
					❒
					❒

Relationship to Applicant should be the relationship of the Household Member to the applicant, not the Guarantor. Examples would be wife, husband, daughter, son, mother, father, step-son, step-daughter, cousin, etc.

Household Income (continued)

Please provide the following information for all incomes you have indicated are received:

Household Member	**Type** *Provide Employer Name if Applicable.*	**Amount**	**Period** *Select one.*	**Start Date**	**End Date** ***(If Applicable)***
			❑Weekly ❑Monthly ❑Biweekly ❑Annually ❑Hrly # hrs/wk _____		
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For all household income received, you must provide supporting documents in order to complete this application. (i.e., tax return, pay stubs, approval letter(s), self-employment schedules, child support statements, etc.)

Assets/Resources (continued)

Please provide the following information for all incomes you have indicated are received:

Household Member	**Type**	**Account Number**	**Value**

For all asset(s)/resource(s) received, you must provide 3 consecutive months statements in order to complete this application.

Other Information (continued)

Please answer the following questions.

Does this household currently have public assistance?

Insurance Company Name & ID number _____

Does patient have health insurance? Should you receive health insurance, please notify the department. Health Insurance is always primary over financial assistance. ❑ Yes ❑ No *If yes, provide the following:*

Insurance Company Name & ID number _____

Insured's Name: _____ Birthdate:_____