Roxborough Memorial Hospital

Financial Assistance Application Form Instructions

This is an application for financial assistance at **Roxborough Memorial Hospital**.

We have two types of financial assistance programs – **Charity Care** and **Discount Payment Program**. You may qualify for free care or discounted care based on your family size and income. To view our financial assistance policy, please go to **www.roxboroughmemorial.com/patients-visitors/financial-assistance**.

What does financial assistance cover? If you are not eligible for a government program and meet certain low- and moderate- income requirements, you may qualify for our Financial Assistance Program. We provide financial assistance to help qualified patients pay for healthcare based on their financial need. This includes emergency, urgent, or medically necessary care. Patients who qualify get some or all of their costs covered regardless of whether they have healthcare coverage, or are uninsured, or are underinsured.

Physicians who practice at **Roxborough Memorial Hospital** are not included in this policy. If you need assistance with the physician bill, you will need to contact the physician's private office and speak to the office staff.

If you have questions or need help completing this application: You may obtain help for any reason, including language assistance, by calling our **Patient Financial Services** at **215-487-4338**. You may also visit the website above.

In order for your application to be processed, you must:

- Provide us information about your family
- Provide us information and documentation about your family's gross monthly income (income before taxes and deductions). *See* Income & Family Household Size section in the financial assistance application for additional information.
- Attach additional information/documents if needed
- Sign and date the form

Mail completed application and supporting documents to:
Roxborough Memorial Hospital, Attention: Patient Financial Services
5800 Ridge Avenue, Philadelphia, PA 19128

You may also submit the application and supporting documents in person at the same address. We will notify you of the final determination of eligibility and appeal rights, if applicable, within 30 days of receiving a complete application and supporting documents. If your application is incomplete, you will receive a letter requesting the required documents to process your application. By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly.
You may continue to receive billing statements until we receive your completed application and supporting documents.

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Financial Assistance Application Form — *Confidential*

Please note we cannot guarantee that you will qualify for financial assistance, even if you apply.

RETURN COMPLETED FORM BY MAIL TO:
Roxborough Memorial Hospital: Patient Financial Services
5800 Ridge Avenue, Philadelphia, PA 19128

You may also submit the application and supporting documents in person at the same address.

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

Application Date:	**Service Date:**
Social Security #: (optional)	☐ I do not have a Social Security #
Patient Name:	**Patient Birthdate:**
Account #:	**Phone #:** ☐ Home ☐ Cell
Street Address, City, State & Zip:	
Is patient currently unhoused? Yes ☐ No ☐	

Please call our **Patient Financial Services** at **215-487-4338** for any questions about filling out this form.

Please check the type of financial assistance you are interested in applying for:
☐ Charity Care
☐ Discount Payment Program

Please note:
(1) The hospital may only request recent paystubs or income tax returns for documentation of income. The hospital may accept other forms of documentation of income but shall not require other forms.
(2) Patients may receive less financial assistance than what may be available to them under the charity care program.

QUESTIONNAIRE:

(1) Was the patient a resident of Pennsylvania at the time of service? Yes ☐ No ☐
(2) Were the medical services received related to a motor vehicle accident, 3rd party injury, or workers' compensation? ***If yes, what is the date of injury?*** _____ Yes ☐ No ☐
(3) Did the patient have any active health insurance at the time of service? Yes ☐ No ☐
(4) Was the patient an active Medi-Cal recipient at the time of service? ***If yes, please attach a copy of your health insurance or Medi-Cal card to this application.*** Yes ☐ No ☐

INCOME & FAMILY HOUSEHOLD SIZE:

- All adult *family* members' income must be disclosed. Income includes gross (before taxes and deductions). Source of income include, for example: wages, unemployment, self-employment, worker's compensation, social security benefits, public assistance, and income drawn from assets (for example: dividends, rental income, mutual funds, IRAs, etc.)
- "Family" is defined as: (1) for persons 18 years of age and older - spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not; and (2) for persons under 18 years of age, parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

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Family Member's Name	Birthdate	Relationship to Patient	Income Source or Employer Name	Income for 3 months from application date	Income for 12 months from application date
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$

- **Proof of Income from all sources MUST be supplied with this application (e.g., 3 most recent months of pay stubs, most recent tax return (IRS Form 1040), etc.).**
- **If you report $0 income**, please provide a written statement of how you (or the patient) are surviving financially, including who provides food, shelter, transportation, etc., and how long you have been without income.

CURRENT EXPENSES (Past 12 months from application date)
We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

Medical Expenses** (hospital, doctor, dental, vision, prescriptions, etc.)	$	Health Insurance Premiums** (medical, dental, vision)	$

****Please provide all receipts/Explanation of Benefits noted above whether paid or unpaid.**

ADDITIONAL INFORMATION

Please attach an additional page if there is information about your current financial situation that you would like us to know, such as financial hardship, excessive medical expenses, or seasonal or temporary income.

PATIENT AGREEMENT

I understand that **Roxborough Memorial Hospital** may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand that if the information I provide is determined to be false, financial assistance may be denied, and I may be responsible to pay for services provided.

Applicant's Signature _____ Date _____