Penn Medicine
Lancaster General Health

555 N. Duke St.
P.O. Box 3555
Lancaster, PA 17604-3555

Date:

Name
Address
Address

Guarantor #

Dear ,

Attached please find a copy of the Lancaster General Health Application for Financial Assistance. The completion of the application is an important first step in the determination of your family's eligibility for financial assistance.

Lancaster General Health will retain copies of all patient information used to determine financial need, as required by federal and state law. **Please be sure to make copies of all necessary documents before returning to Lancaster General Health as we will not return your originals.**

You may receive patient bills until your application has been processed. **Please complete all questions on this application and return within 14 days. Failure to complete all questions and provide all documentation may result in your application being denied.**

Federal and state laws require all health care providers to seek payment for care provided, while also providing opportunities for financial assistance for those individuals who qualify. It is important that a completed application be submitted for consideration as unpaid bills may be turned over to a collection agency.

If you have any questions regarding the completion of this application, please contact a Financial Counselor at 717-544-1957. Information is also available on our website at www.LGHealth.org/Financial-Assistance.

Sincerely,

Financial Counseling Team

Penn Medicine
Lancaster General Health

INTERNAL USE ONLY			
MRN:		CSS:	
GUAR #:		FACILITY:	

APPLICATION FOR FINANCIAL ASSISTANCE

Please complete all questions on this application. *Failure to complete all questions and provide all documentation will result in delays in evaluating eligibility and/or denial of financial assistance. Please mark any question that does not apply to you with 'N.A.'*

Patient Information

Patient Name: _____ Date of Birth:_____

Street Address: _____

City/State/Zip: _____

Home Telephone: _____ Work Telephone: _____

USA Citizen _____Non USA Citizen _____Undocumented _____

Dependents:

Please list spouse and all dependents under 18 years of age. Any household members over 18 unless currently in high school or disabled must complete their own application.

Are you pregnant? Yes_____ No _____

	Name	Relationship	Date of Birth	Name of Insurance and ID Number
1.		Self		
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Gross Monthly Household Income

Gross Wages (Before Taxes): _____ Pensions: _____
Social Security Income: _____ Other Disability: _____
SSI: _____ Cash Assistance: _____
Unemployment Compensation: _____ Worker's Comp: _____
Child Support: _____ Spousal Support: _____
Other (Please explain): _____

Assets

List bank accounts, with account numbers and balances. Include all Checking accounts, Savings accounts, Investment accounts, Mutual Funds, Stocks, and Bonds. Please list each separately.

Bank	Account Number	Balance

Other financial assets:

_____

_____

_____

Verification of Income

Please return the completed application and the following documentation within 14 days.
Failure to complete all questions and provide all documentation may result in denying your financial assistance application.

	Completed and signed Financial Assistance Application
	Complete current Federal Tax Return including all schedules and documents supporting tax return
	Complete copy of last 1 months (4 weeks) of consecutive pay stubs
	Complete copy of last 1 month of bank statements for all accounts (all pages)
	Current unemployment letter with weekly benefit amount.
	2017 Social Security award letter or 2016 SSA-1099
	Child and/or spousal support letter
	If someone is assisting you with daily needs by any of the following: • Providing room and board • Lending you money • Paying you directly to cover your expenses • Paying your expenses on your behalf You and the financial supporter will need to complete a statement of support in person in our Patient Financial Services office located at Lancaster General Hospital on Duke Street or Suburban Outpatient Pavilion. Photo ID will be required for both parties.
	Any other letters: □ Pension □ Cash Assistance □ Disability □ Workers Comp □ Loan "due on demand" □ Other: _____
	Exemption Certificate Number ECN# and any supporting documentation verifying exemption from Affordable Care Act insurance program

List any other financial considerations or relevant information that my help in making a decision: _____

_____

_____

Certification

I certify that the information contained in this financial statement is true and accurate, and I understand that any false information may result in legal action against me. I understand that Lancaster General Health reserves the right to verify any financial and/or credit related information contained in this form.

Lancaster General Health will retain copies of all patient information used to determine financial need, as required by federal and state law.

I further certify that I understand there is now a federally mandated insurance program available through the Affordable Care Act. Failure to enroll and remaining uninsured may affect the level of financial assistance offered by Lancaster General Health.

☐ **I DO** ☐ **I DO NOT (Please check one) give permission to Lancaster General Health to notify my attending physician(s) of its determination in the event this request for financial assistance is approved by Lancaster General Health, in whole or in part. I understand that any decision to waive my physician fees is the responsibility of my attending physician(s), and not Lancaster General Health.**

_____ _____

Signature of Responsible Person Date

If you have any questions regarding the completion of this application, please contact a Financial Counselor at 717-544-1957.

Please mail completed application along with documentation to:

Lancaster General Health
Attn: PFS, Customer Service Dept
FA Program
PO Box 3555
Lancaster, PA 17604-3555