Penn Medicine
Lancaster General Health

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

Date:

Name
Address
Address

Guarantor:

Dear,

Attached is a copy of the Penn Medicine Lancaster General Health's application for Financial Assistance. This application allows us to assess if your family may be eligible for the program. It is important that you submit all requested documents.

You may still receive bills until we review your application.

For the application, please:

- ☐ **Fill out all questions and send all requested documents.**
  - If you do not complete all questions and include all documents, we may deny your application.
- ☐ **Make copies of all documents before sending your application. We will not return your originals.**
  - Penn Medicine Lancaster General Health will keep copies of all information that we use to review your application. This is part of federal and state law.
- ☐ **Submit your application using one of the methods below**
  - **Online using MyLGHealth**
  - **Mail application and all documents to:**
    Lancaster General Health
    Attn.: PFS Customer Service Dept.
    FA Program
    PO Box 3555
    Lancaster, PA 17604-3555
- ☐ **Send back within 14 days**

Federal and state laws require providers to seek payment for the care they provide. Providers must also have options for financial assistance for those who qualify. Unpaid bills may be turned over to a collection agency.

If you have any questions, please call a Financial Counselor at 717-544-1957. For more information, visit lghealth.org/financial-assistance.

Sincerely,
Financial Counseling Team

MRN: _____ CSS: _____

Application For Financial Assistance

Please make sure all information below is correct. Be sure to send all documents.
If you do not sign the application and send in **all documents**, your application will be denied.

Patient Information

Patient Name: _____ **Date of Birth:**_____ **Phone**:_____

Address/City/State/Zip: _____

US Citizen? Yes / No **Undocumented?** Yes / No **Pregnant?** Yes / No

Name of Household Member	Relationship to patient	Date of Birth	Insurance Name and ID # (if applicable)
1.			
2.			
3.			
4.			
5.			

Please send these documents (all that apply):

- ☐ Federal Tax Return, 1040
- ☐ 30 days of pay stubs
- ☐ 30 days of **all** bank statements (Checking **and** Savings)
- ☐ Social Security award leter or 1099
- ☐ Statement of support (with photo ID)
- ☐ Unemployment award letter
- ☐ Child or spousal support
- ☐ Cash assistance/SNAP award letter
- ☐ Short/Long Term Disability award letter
- ☐ Pension/Retirement
- ☐ Workers' Compensation award letter
- ☐ Loan "Due on Demand"

List any other financial factors or information that may help in making a decision:

_____

Certification

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

Lancaster General Health will keep copies of all patient information used to assess financial need. This is part of federal and state law.

I certify that I understand there is now a federally mandated insurance program through the Affordable Care Act. I know that I can decide to not enroll and remain without insurance coverage. I know that this decision may affect the level of financial assistance from Lancaster General Health.

☐ **I Do** ☐ **I Do Not** (check one) give permission for Lancaster General Health to notify my treating physician(s) if my application for Financial Assistance is approved (in whole or in part). I understand that I may be treated by providers that are not employed by Lancaster General Health and who may choose not to participate in the Lancaster General Health Financial Assistance Plan.

_____ _____

Signature of Applicant Date