Financial Assistance Application

Guarantor ID/MRN: _____

Patient Name: _____ Date of Birth: _____

Home Address: _____

Street City State Zip

Telephone Number: (H) _____ (C) _____ Best time to call? _____

☐ **I certify that I am a member of an Anabaptist group whose established beliefs prohibit participation in or applying for Medicaid.**

Do you have a Sharing Plan? Yes ☐ No ☐

Name of Plan: _____ % of payment: _____

Deacon's Name: _____ Phone Number: _____

Conference/Church Group: _____

Household Members – (Include only people listed on most recent yearly tax return. If household has more than seven members, please add additional members on page 2 of application.)

Name:	Relationship	DOB
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____

Monthly Gross Income Received from ALL Household Members listed above:

Wages/Salaries (before taxes): _____
Social Security Income: _____
Unemployment/WC Compensation: _____
Veteran's Administration (VA) benefits: _____
Pensions/Annuities: _____
Cash Assistance: _____
Child Support: _____ Spousal Support: _____
Unearned Income (Trusts, interest, rental, disability): _____

Household Countable Resources: Please list your available accounts and liquid assets for your household. A liquid asset is defined as cash or any type of negotiable asset that can be converted quickly and easily into cash. Do not include your home, household items, vehicles, IRA, 401 (K) accounts and other non-liquid assets.

Checking: _____
Savings: _____
Health Savings Acct (HSA)/ (HRA): _____
Christmas/Vacation Club: _____
Stocks/ Bonds/Mutual Funds/Money Market: _____
Certificate of Deposit: _____
US Savings Bonds: _____
Trust Fund: _____
Mobile application services (paypal, cash app, venmo, apple pay ect.) _____
Other (please explain): _____

Verification of Income and resources must accompany application (Please attach the following if applicable):

☐Yes ☐No Most recent Complete Federal Tax Return. Personal and/or business (profit and loss).
☐Yes ☐No Current/Consecutive pay stubs for the last 30 days for each working applicant in the household.
☐Yes ☐No Award letters showing deposits of Social Security, other disability, pension, worker's comp, or unemployment compensation payments.
☐Yes ☐No Child/Alimony supporting documentation
☐Yes ☐No 3 Current/Consecutive statements for all household members including checking/savings/paypal/mobile application services, all pages. If self-employed 6 current/ Consecutive bank statements all personal and all business.
☐Yes ☐No Written explanation of all deposits over $100 in bank accounts (excluding direct deposits and Social Security
☐Yes ☐No Verification of countable resources
☐Yes ☐No If the household has no income, letters from persons who are assisting with daily living needs explaining the help that the person provide.
☐Yes ☐No Verification of all monthly expenses for Medicare eligible applicants.

Do you have a health insurance plan? Yes ☐ No ☐ **If no, why?** _____

Have you applied for Medical Assistance? Yes ☐ No ☐ **If yes, please attach notice**

Have you applied for affordable care insurance through Affordable Care Act (ACA)? Yes – No **If yes, please attach notice**

I certify that the information I have provided is true and accurate. I understand that any false information or not giving complete information will void this application. This information is for qualification purposes only. I also understand that this information may be shared with my Community Deacon if applicable. To process your application, we require supporting income information. We will work with you to assess your qualifications for the program based on information supplied to WellSpan Health. Applicants understand that if they do have a sharing plan, this application will be held until we receive payment from the sharing plan's portion to be paid. After payment is received, we will then move forward with review for approval on patient's remaining balance. You may still receive bills until we receive your supporting documentation to complete your application.

Applicant's Signature: _____ Date: _____

Submit your completed and signed application along with all required documentation and/or have any questions regarding the application process:

Phone: 717-851-5051 Monday – Friday 8am-4pm
Fax: 717-851-3100
Email: WSHFinancialAssistance@wellspan.org
Mail: PO Box 20607 York, PA 17402

ADDITIONAL HOUSEHOLD MEMBERS (Continued from Page 1 if needed)

Household Members – (Include only people listed on most recent yearly tax return. If household has more than seven members, please add additional members on page 2 of application.)

Name:	Relationship	DOB
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

WellSpan York Hospital/
WellSpan Medical Group
York County
1001 S George St.
PO Box 15198
York, PA 17403
(717)851-5051 (phone)
(717)851-3100 (fax)
Monday – Friday 8 a.m.– 4 p.m.

WellSpan Philhaven/
WellSpan Medical Group
Lebanon County
283. S. Butler Rd.
Mt. Gretna, PA 17064
(717)851-5051 (phone)
(717)851-3100 (fax)
Monday – Friday 8 a.m.– 4 p.m.

WellSpan Evangelical Community Hospital/WellSpan Medical Group
Lewisburg County
1 Hospital Dr
Lewisburg, PA 17837
(717)851-5051 (phone)
(717)851-3100 (fax)
Monday – Friday 8 a.m.– 4 p.m.

WellSpan Ephrata Community Hospital/
WellSpan Medical Group
Lancaster County
169 Martin Ave.
Ephrata, PA 17522-1002
(717)851-5051 (phone)
(717)851-3100 (fax)
Monday – Friday 8 a.m.– 4 p.m.

WellSpan Good Samaritan Hospital/
WellSpan Medical Group
Lebanon County
4th & Walnut Streets
Lebanon, PA 17042
(717)851-5051 (phone)
(717)851-3100 (fax)
Monday – Friday 8 a.m.– 4 p.m.

WellSpan Gettysburg Hospital/
WellSpan Medical Group
Adams County
147 Gettys St.
Gettysburg, PA 17325
(717)851-5051 (phone)
(717)851-3100 (fax)
Monday – Friday 8 a.m.– 4 p.m.

WellSpan Chambersburg Hospital/
WellSpan Medical Group
Franklin County
112 N 7th St.
Chambersburg, PA 17201
(717)851-5051 (phone)
(717)851-3100 (fax)
Monday – Friday 8 a.m.– 4 p.m.

WellSpan Waynesboro Hospital/
WellSpan Medical Group
Franklin County
501 E. Main St.
Waynesboro, PA 17268
(717)851-5051 (phone)
(717)851-3100 (fax)
Monday – Friday 8 a.m.– 4 p.m