Financial Assistance Application

MRN:_____

Patient Name: _____ Date of Birth: _____

Home Address: _____
Street City State Zip

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

Household Members – (Include only people listed on yearly tax return and/or significant other)

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

Monthly Gross Income Received from ALL Household Members listed above:

Wages/Salaries (before taxes): _____ Pensions/Annuities: _____

Social Security Income:_____ Cash Assistance: _____

Unemployment/WC Compensation: _____ Child Support: _____ Spousal Support:_____

Veteran's Administration (VA) benefits: _____ 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: _____ Stocks/ Bonds/Mutual Funds/Money Market: _____

Trust Fund: _____ Health Savings Acct(HSA)/ (HRA): _____

Certificate of Deposit: _____ Pay Pal: _____

US Savings Bonds: _____ Christmas/Vacation Club: _____

Other (please explain):_____

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

Attached:

- N/A Complete Federal Tax Return (most recent year). Personal and/or business.
- N/A Current pay stubs for the last 30 days for each working applicant.
- N/A Award letters showing deposits of Social Security, other disability, pension, worker's comp, or unemployment compensation payments.
- N/A 3 current Checking/Savings/Pay Pal statements, all pages. If self-employed – 6 current bank statements personal and business.
- N/A Written explanation of all deposits over $100 in bank accounts (excluding direct deposits and social security)
- N/A Verification of all countable resources.
- N/A Child/Alimony supporting documentation
- N/A Documentation of other sources of income
- N/A If the household has no income, letters from persons who are assisting with daily living needs, explaining the help that the persons provide.
- N/A If self-employed, please provide Profit & Loss
- N/A Verification of all monthly expenses for Medicare eligible applicants.

Do you have a health insurance plan? N/A If no, why? _____

Have you applied for Medical Assistance? N/A If yes, please attach notice

Have you applied for Affordable Care Insurance? N/A 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.

Applicant's Signature: _____ Date: _____

Approved Date: _____ Approved %: _____

Effective Date: _____ Denied Date: _____

Patient Financial Representative: _____ Date: _____

Supervisor: _____ Date: _____

Important Information:

- ☐ Please complete, sign and date the application.
- ☐ In order to process your application, we do require supporting income information. Please enclose this with your application. We will work with you to assess your qualifications for the program based on information supplied to WellSpan Health. Please understand, we will not share the information you provide – this information is for qualification purposes only.
- ☐ Please call with any questions about completing the application or program qualifications.

Please email with questions and send your completed, signed application with required documents to*:*

***WSHFinancialAssistance@wellspan.org*.**

WellSpan York & Adams County Hopsital/WellSpan Medical Group
601 Memory Lane
York, PA 17402
(717)851-5051 (phone)
(717)851-6904 (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)733-6066 (fax)
Monday – Friday 8 a.m.– 4 p.m.

WellSpan Chambersburg Hospital
760 E. Washington St
Chambersburg, PA 17201
(717)267-7129 (phone)
(717)267-7597 (fax)
Monday – Friday 8 a.m.– 4 p.m.

WellSpan Philhaven
283. S. Butler Rd.
Mt. Gretna, PA 17064
(717)675-1111 (phone)
(717)270-2449 (fax)
Monday – Friday 8a.m – 4 p.m.

WellSpan Good Samaritan Hospital/ WellSpan Medical Group – Lebanon
4th & Walnut Streets
Lebanon, PA 17042
(717)851-5051 (phone)
(717)270-3788 (fax)
Monday – Friday 8 a.m. – 4 p.m.

WellSpan Waynesboro Hospital
501 E. Main St
Waynesboro, PA 17268
(717)267-3406 (phone)
(717)267- 3447(fax)
Monday – Friday 8 a.m.– 4 p.m.

WellSpan Medical Oncology and Hematology/ WellSpan Radiation Oncology
22 St. Paul Drive, Suite 101
Chambersburg, PA 17201
(717)217-6020 (phone)
(717)217-6939
Monday – Friday 8 a.m. – 4:30 p.m.

WellSpan Summit Physician Services
785 Fifth Avenue, Suite 3
Chambersburg, PA 17201
(717)263-9555 (phone)
(717)709-6529 (fax)
Monday – Friday 8 a.m. – 5 p.m.

We want to help. Please submit your completed application promptly!

You may receive bills until we receive your completed application and supporting documents.