Patient Financial Assistance Program

Application Form

Section 1: Applicant Information

Name of Head of Household:

_____

Applicant's Date of Birth:_____ Applicant's Social Security Number:_____

Address:_____

Daytime Phone Number:_____ Alternate Phone Number:_____

Section 2: Complete this section for yourself and all other persons living in your household

Names	*Social Security Number-relationship*	*Date of Birth*

Section 3: Explain why you are in need of Patient Financial Assistance

_____

_____

_____

_____

Section 4: Monthly Household Income: Give the monthly income of yourself and other household members.

	Self	*Spouse and/or other household members*
Wages/Salaries/Commissions/tips	$_____	$_____
Self-Employ/Rental Income	$_____	$_____
Unemployment or Workers Comp.	$_____	$_____
Social Security, VA or UMW benefits	$_____	$_____
Pension or Retirement Income	$_____	$_____
Sick or Union Benefits	$_____	$_____
Dividends and interest	$_____	$_____
Child Support or Alimony	$_____	$_____
Cashed Insurance policies	$_____	$_____
Inheritance/Lawsuit settlement		
Scholarships received in last 12 mo.	$_____	$_____
Total Monthly Household Income	$_____	$_____

Section 5: Liquid Assets: Give total of ALL liquid assets for yourself and other household members (including those that may be through an employer)

	Self	*Spouse and/or other household members*
Cash on hand	$_____	$_____
Checking Account(s) List All	$_____	$_____
Savings Account(s) List All	$_____	$_____
Credit Union/Christmas or		
Vacation Club(s)	$_____	$_____

Section 6: Answer questions about ownership of real estate.

Real Estate Value: $_____

Other Property: $_____

NOTE:

1 .All applicants must provide a copy of their most recent signed tax return (form 1040)

☐ Check here if you **DO NOT** file and income tax return

Reason no tax return filed:_____

2. Include proof of household income:

(If You Have No Income: Provide a letter of support from the person or person(s) who provide your support).

3. Proof of Liquid assets (current checking/savings bank statement)

4. Copy of the Medical Assistance Determination Notice

Disclaimer: I have read this application in full or have had it read to me. I understand the information I have provided will be used only by Excela Health to process my Patient Financial Assistance Application and all information provided will remain confidential. I understand the documents sent to Excela Health to be used in the financial assistance process will not be returned to me. I agree to provide or cooperate in obtaining any additional document needed for the financial assistance process. I certify that all information supplied in this application is true and accurate to the best of my knowledge. If any information that I have given proves to be untrue, Excela Health may reverse any financial assistance that has been approved, making me liable for the balance(s).

_____ _____

Signature Date

_____

Relationship to Patient(s)

Complete this section only if the patient is deceased:

I certify that _____ is deceased and have provided proof to Excela Health. In addition any estate information will be provided to Excela Health. The executor/executrix of the estate is _____ and can be contacted at _____.

_____ _____

Signature Date

_____

Relationship to Patient(s)