Application Form

This application applies to the following:
Frick Hospital, Latrobe Hospital, Westmoreland Hospital, Excela Health Medical Group

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 people living in your household

Name	*Social Security Number*	*Relationship*	*Date of Birth*

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

_____

_____

_____

Section 4: Monthly Household Income: Provide the monthly income for yourself and 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: Provide total of ALL liquid assets for yourself and 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 WVU Medicine to process my Patient Financial Assistance Application and all information provided will remain confidential. I understand the documents sent to WVU Medicine 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, WVU Medicine 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 WVU Medicine. In addition any estate information will be provided to WVU Medicine. The executor/executrix of the estate is _____ _____ and can be contacted at _____.

_____ _____

Signature Date

_____

Relationship to Patient(s)