Return Application by _____

Financial Assistance Application

Applicant_____ Date of Birth _____ Social Security Number _____-_____-_____

Address_____

Telephone Number_____ **Please Circle One** Married Single Separated Divorced Widowed

If married or separated, please answer the following questions.

Spouse's Name _____ Date of Birth _____ Social Security Number _____-_____-_____

Applicant	Spouse	
Are you currently employed? _____ Yes Hourly Pay Rate $_____ Hours Per Week _____ _____ No If no, please attach a copy of your unemployment benefits. If you do not receive unemployment benefits, please attach a letter explaining your means of support with a signature by the person providing the support. Who was your previous employer? _____ Date last worked _____	Are you currently employed? _____ Yes Hourly Pay Rate $_____ Hours Per Week _____ _____ No If no, please attach a copy of your unemployment benefits. If you do not receive unemployment benefits, please attach a letter explaining your means of support with a signature by the person providing the support. Who was your previous employer? _____ Date last worked _____	Do either you or your spouse draw Social Security? ____ Yes If yes, please attach a letter from Social Security verifying how much you make per month. **Other Income** Child Support $_____ Alimony $_____ SNAP Benefits $_____ Other $_____ ➢ If other, please explain source of income given. _____ _____

How many people live in your household? _____ Number of Dependents in household? _____

List full name and date of birth for each dependent.

1. Name_____ Date of Birth_____
2. Name_____ Date of Birth_____
3. Name_____ Date of Birth_____

Please list all property owned (Home, Land, Vehicles, etc.)

1. _____ Value $_____
2. _____ Value $_____
3. _____ Value $_____
4. _____ Value $_____

In order to process your request for financial assistance, we will need the following documents along with your completed application returned to the Patient Financial Counselor by the due date located at the top of the first page.

_____ An itemized checking and savings account statement for the previous month
_____ A copy of your most recent tax return
_____ If you receive SNAP benefits, a copy of your award letter
_____ Personal property tax tickets (Vehicles, home, land, etc.)
_____ Check stubs for the previous three months
_____ Denial letter from the Department of Social Services or First Source stating you do not qualify for assistance.
_____ Exemption number and Application ID from Healthcare.gov

If for any reason you are unable to provide the documents requested, please explain:

I understand that this form will be used to evaluate my ability to pay my hospital bill(s). I agree to cooperate with Wythe County Community Hospital in pursuing reimbursement from any available insurance or other medical payment programs and in verifying the information on this form. I also understand that all or part of my indebtedness to Wythe County Community Hospital may be reduced if I qualify under the current Wythe County Community Hospital Charity Care Guidelines. Assignment of Benefits – I hereby assign to Wythe County Community Hospital, to such extent necessary to satisfy my outstanding indebtedness to Wythe county community Hospital or any of its affiliates, all sums payable to me pursuant to any health benefit, plan, policy or insurance (including but not limited to health, liability, uninsured or underinsured motorists, or medical payments insurance) and/or pursuant to any settlement or judgment arising out of or related to any incident which caused or causes my admission or medical treatment. This Assignment is given in consideration of medical services rendered to date, in consideration of Wythe County community Hospital considering the reduction of my indebtedness under the Wythe County Community Hospital Charity Care Program and in consideration of future care which may be rendered to me or members of my household. I hereby certify that the information contained on this questionnaire is correct and accurate and I hereby authorize any and all parties to release any information necessary to confirm any information on this questionnaire including the amount of my assets and income. I further authorize and agree that Wythe County Community Hospital or its affiliates may obtain personal credit reports with respect to me. If any I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Applicant's Signature _____

Date _____

Patient Financial Services Director _____

Date _____

Application can be submitted in person or by mail to the following address:

For any questions please contact our Benefits Advisor at **(276) 228-0245.**

Wythe County Community Hospital
Attn: Benefits Advisor
600 West Ridge Road
Wytheville, VA 24382