APPLICATION FOR PATIENT FINANCIAL ASSISTANCE

Name: _____ **Last 4 digits of Social Security #:** _____ **Date of Birth:** _____

Current Address: _____
NUMBER & STREET CITY STATE ZIP

Home Telephone: _____ Cell Phone: _____

Previous Address if you have lived at
Current Address less than 2 years: _____
NUMBER & STREET CITY STATE ZIP

Do you rent or own your Home? ☐ Own ☐ Rent

Are you and/or any immediate family member residing in your household currently employed? ☐ Yes ☐ No
If YES, list the name of the person employed and his/her employer. Please remember to include yourself.

_____ _____
Name Employer

_____ _____
Name Employer

_____ _____
Name Employer

If YES, is medical insurance available to you through any of these employers? ☐ Yes ☐ No

Are you covered under any other person's medical insurance? ☐ Yes ☐ No

If you do not work, how long have you been unemployed? _____

Please list names of people who live in your house, their relationship, and dates of birth

Name	**Relationship**	**DOB**

Please attach the following for each household member. If unable to supply, please indicate the reason:

1. **1 Month of Pay Stubs:**
2. **Unemployment Compensation Check Stubs:**
3. **Income Tax return (Signed & Most Recent Year) including W-2 Withholding Statement:**
4. **DPA/MA Denial/Rejection:** (web link for MA application: www.compass.state.pa.us)
5. **Disbursement letter from Social Security Office for annual income verification.**

Other Resources: Does anyone in your household have any of the following resources?

- ☐ **Yes** ☐ **No** **Savings Account.** Current balance:
- ☐ **Yes** ☐ **No** **Checking Account.** Current balance:
- ☐ **Yes** ☐ **No** **US.Savings Bonds.** Face Value:
- ☐ **Yes** ☐ **No** **Certificate of Deposite.** Face Value:
- ☐ **Yes** ☐ **No** **Trust Fund.** Current balance:
- ☐ **Yes** ☐ **No** **Stock or Bonds.** Current Value:
- ☐ **Yes** ☐ **No** **IRA, KEOGH, or Other Retirement Plan.** Current balance: _____

Patient's Gross Annual Income:	$ _____
Other Family Income:	+$ _____
Total Family Income:	$ _____

I acknowledge that the information provided is true and correct. I authorize Brandywine Hospital to verify any information contained in this document for the sole purpose of assessing financial need.

I understand that if my financial situation or availability of resources changes, I am required to notify the Hospital of the change for the purpose of being reassessed for this program.

_____ _____
Signature of Patient Date