FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

TAH strives to make certain that the financial circumstances of individuals who require health care services; does not prevent them from seeking or receiving care.

Attached you will find an application for the Titusville Area Hospital Financial Assistance Program. This program complies with all federal, state, and local laws, rules and regulations.

If you wish to be considered for Financial Assistance, please complete the application and return it to our Financial Assistance Office along with the required documentation at:

Titusville Area Hospital
Financial Assistance Office
406 West Oak Street
Titusville, PA 16354

The following proof of income documents are required in order to process your application upon receipt:

- Federal tax return including W-2(s)
- Payroll stubs for last 3 months
- Bank statements for current month and/or other income verification (last 3 months)

If you have any questions, please contact us at:

(814) 827-1851, Ext. 4740 or 2060
Toll Free (800) 950-1851, Ext. 4740 or 2060

FINANCIAL ASSISTANCE APPLICATION

Patient Name(s): _____

Account #(s): _____

GUARANTOR	**SPOUSE (Significant Other)**
Name Date of Birth	Name Date of Birth
Social Security Number Phone Number	Social Security Number
Current Address # years: _____ [ ] Own [ ] Rent	Current Address # years: _____ [ ] Own [ ] Rent
Street:	Street:
City/State/Zip	City/State/Zip
Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widow(er) Total # residing in household:	Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widow(er) Total # residing in household:
Name & Address Of Employer: Position/Title: Yrs. Employed:	Name & Address Of Employer: Position/Title: Yrs. Employed:
Previous Employer(s) (if within the last year): Date of Termination:	Previous Employer(s) (if within the last year): Date of Termination:

Please list any dependent children as reported on your last Federal tax return. Attach a separate sheet if necessary.

Child's Name	Date of Birth

Documentation Needed for Financial Assistance

The following proof of income documents are required with the application:

- **Federal tax return including W2(s) for year(s): _____**
- **Payroll stubs for last 3 months**
- **Bank statements for current month and/or other income verification (last 3 months)**

We ask all who apply for financial assistance to look for other funding also. Please check "YES" or "NO".

Does your employer or your spouse's employer offer group health insurance? [ ] YES [ ] NO If yes, list _____

Does your employer reimburse you for any deductible? [ ] YES [ ] NO

Do you have a Health Savings/Flex Savings Account? [ ] YES [ ] NO If yes, balance _____

Are you eligible for COBRA through a previous employer? [ ] YES [ ] NO

Do you have other types of insurance such as Allstate, AFLAC, etc.? [ ] YES [ ] NO If yes, list _____

Where you denied Medicaid? [ ] YES [ ] NO
(A Medicaid denial is not required to qualify for the financial assistance program at Titusville Area Hospital.)

Have you applied for State assistance programs (CHIP, Marketplace, etc)? [ ] YES [ ] NO

Do you have family or church assistance? [ ] YES [ ] NO

MONTHLY INCOME			
	Guarantor	Co-Applicant	Total
Wages	$	$	$
Social Security			
Self Employed			
Pensions			
Work Comp.			
Interest/Dividends			
Rental			
Disability/SSI			
Military Benefits			
Child Support			
Alimony			
Unemployment			
Other			
Total Monthly Household Income			**$**

ASSETS		
Type	Financial Institution (s)	Total Balance
Cash		
Savings Account(s)		
Checking Account(s)		
Stocks or Bonds		
401(k)		
IRA		
Other		

Additional information you wish to provide. Attach additional pages if necessary.

_____

_____

_____

_____

I hereby state that the information given herein is true and correct. I authorize any required verification, including credit bureau report. I understand that if this information is determined to be false or deceptive, I will be liable for payment of charges for all services rendered. I understand that this request for financial assistance may not pertain to other health care providers.

Responsible Party Signature: _____ Date: _____

Checklist of all required information to complete the application process:

[ ] Front and back of application filled out completely
[ ] Application is signed and dated
[ ] Household income verification for past 3 months
[ ] Copy of Medicaid determination letter (if applicable)

FOR BUSINESS OFFICE USE ONLY

Reviewed By: _____ Date: _____

Determination: Approved [ ] _____% Denied [ ] Reason: _____

Date Applicant Notified: _____ Method of Notification: _____

Reviewer Signature: _____ Date: _____

Manager Sign Off: _____ Date: _____