Process To Apply For Charity Care

All applicants must provide the following information.

1. A completed and signed application.

2. A copy of your most recent W-2 form or other proof of income information.

3. Proof of income is mandatory. If W-2 copies are not available, copies of bank statements showing income deposits or pay stubs showing gross income for the past 3 months are acceptable.

4. A copy of the Medical Assistance denial if applicable. **Note:** Charity Care applicants are requested to apply for Medical Assistance if the patient had an inpatient stay (admitted to the hospital).

Please be advised, we will **not** be able to approve the application if the information received is incomplete. You **must** attach verification of income for your application to be processed. Provided all the necessary information is received, the application will be processed in 2 days for determination. A letter will be sent to you making you aware of the determination. If you have any questions regarding the Charity Care application process, please call the Business Office at 724-888-5688.
Please return the above information as soon as possible to:

Heritage Valley Health System
Attn: Charity Care
200 Ohio River Boulevard
Baden, PA 15005

PLEASE RETURN THE COMPLETED APPLICATION IN THE ENCLOSED ENVELOPE.

Heritage Valley Health System

Charity Care Application

NAME_____ **DATE**_____

ADDRESS_____ **PATIENT NAME**_____

_____ **ACCOUNT #** _____

TOTAL NUMBER OF FAMILY MEMBERS_____ **PATIENT BIRTHDATE**_____

List Spouse and All Dependents **TELEPHONE NO.** _____

NAME: RELATIONSHIP: DATE OF BIRTH:

GROSS INCOME: This should include wages before taxes, or income from public assistance, alimony, social security, unemployment, workers compensation, strike benefits, veteran's benefits, military allotments, pension or annuity, dividends, estates, trusts, interest, training stipends, or income from rent. **Note:** If you are self-employed, your gross income will be total receipts less business deductions.

TYPE OF INCOME	**MONTHLY**	**YEARLY**
Head of household	_____	_____
Spouse	_____	_____
Self-Employment	_____	_____
Social Security	_____	_____
Unemployment	_____	_____
Pension, Interest, Dividends	_____	_____
Other	_____	_____
Total:	_____	_____

I certify that the above information is true and complete to the best of my knowledge. I understand that fraudulent statements could result in my disqualification from this program. I understand the Charity Care decision will be based on the verified review of this application, and that this program only applies to medical services rendered at **Heritage Valley Beaver** or **Heritage Valley Sewickley**, and does not include any physician services.

Signature:_____ **Date:**_____

For Office Use Only:
Approval Date:_____
Qualified For:_____
Expiration Date:_____
Initials:_____