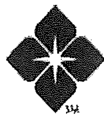


Heritage Valley Beaver
1000 Dutch Ridge Road
Beaver, PA 15009

Heritage Valley Kennedy
25 Heckel Road
McKees Rocks, PA 15136

Heritage Valley Sewickley
720 Road Blackburn Rd
Sewickley, PA 15143

Financial Assistance "Charity Care Program" Application Packet

Heritage Valley Health System offers financial assistance to all patients who meet its Charity Care Program policy guidelines. The requested documents and information in the application are required by **The Centers of Medicare & Medicaid Services** (CMS) and are necessary for auditing purposes.

ALL supporting documents must be included with the application to ensure timely processing. Failure to provide all required documents will delay, or result in a denial of, Charity Care.

1. Complete and return the Charity Care Application included in this packet along with **copies** of the required supporting documents. Original documents will not be returned.
2. Proof of ALL income, assets and expenses is required by CMS regulation.

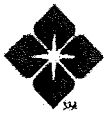
   Acceptable proof of income (money you *receive*) can be any of the following:
   - ✓ Most recent IRS 1040 tax form
   - ✓ Pay stubs for last 30 days
   - ✓ Social Security, Unemployment or Worker compensation award letters
   - ✓ If self-employed, the application must include full tax return or other documents that prove income

   Acceptable proof of assets (money you have in bank accounts, credit unions, stocks, bonds or other accounts) can be any of the following:
   - ✓ Most recent checking/savings account statements
   - ✓ Annual Certificate of Deposit (CD) statement
   - ✓ Credit Union statements

   Proof of expenses (bills you pay) should be copies of those bills/statements.
3. **Note:** IF the person applying for Charity Care was admitted to the hospital, he/she are requested to apply for Medical Assistance and provide proof of that denial along with this application.
4. If the patient is deceased, please provide a copy of the death certificate and letter indicating the status of the estate.
5. **Send the completed and signed application to:**

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

Please be advised, we will **not** be able to evaluate your eligibility for Charity Care if the information received is incomplete. You **must** provide proof of income, assets and expenses for the application to be processed. All applicants will receive a letter with the Charity Care determination. If you have questions, please call the Business Office at 724-888-5688.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HERITAGE VALLEY
HEALTH SYSTEM

Charity Care Program Application

PATIENT NAME: ______________________________

DATE OF BIRTH: __________________ **SOCIAL SECURITY#:** __________________

ADDRESS: ______________________________

DAY TIME PHONE NUMBER: __________________ **CELL PHONE:** __________________

Household Information: List all members living in household that appear on the most recent IRS 1040 Form:

NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH

Monthly Gross Income: This should include wages before taxes for all members living in the household. **Note:** If you are self-employed, you must include the most recent full tax return or most recent financial statements.

	SELF	SPOUSE / OTHER HOUSEHOLD MEMBERS
Wages/Salary/ Tips		
Self-Employment Income		
Social Security		
Pension		
Rental Income		
Workers Compensation		
Unemployment		
Alimony / Child Support		
Interest / Dividends		
Other Income		
Total		

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HEALTH SYSTEM

Other household assets – Checking Accounts, Savings Accounts, Health Savings Accounts, Credit Union, Stocks/Bonds, Certificate of Deposit, Other.

ACCOUNT TYPE	BANK / INSTITUTE	BALANCE

Monthly Expenses: Monthly Expenses (i.e. Mortgage/Rent, utilities, real estate taxes)

TYPE OF EXPENSE	MONTHLY PAYMENT

ADDITIONAL COMMENTS or SPECIAL CIRCUMSTANCES:
Please include any patient account number on statements you are receiving.

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 supporting documentation. I understand that the documents provided to prove my assets and income will not be returned. This program applies to medical services rendered at **Heritage Valley Beaver**, **Heritage Valley Kennedy** or **Heritage Valley Sewickley**, and does not include any other medical bills I may have such as physician services, radiology, ambulance, etc.

Signature: ______________________________ **Date:** __________

For Office Use Only:
Qualifying Income Amount: ____________
Qualified Percentage: ____________
Approval Date: ____________
Expiration Date: ____________
Initials: ____________