MAIN LINE HEALTH CHARITY CARE AND FINANCIAL ASSISTANCE APPLICATION

July 22, 2011

FACILITY: _____ **PATIENT #** _____

PATIENT NAME: _____ **DATE OF SERVICE:** _____

SOCIAL SECURITY NUMBER: _____ **BALANCE:** _____

PATIENT ADDRESS: _____

CITY _____ **STATE** _____ **ZIP CODE** _____

I HEREBY CERTIFY THAT I AM CURRENTLY UNINSURED AND DO NOT HAVE THE FINANCIAL ABILITY TO PAY FOR THE HOSPITAL TREATMENT RECEIVED ON THE DATE STATED ABOVE.

I UNDERSTAND THAT BY SIGNING THIS DOCUMENT, I AM APPLYING FOR CHARITY CARE AND/OR FINANCIAL ASSISTANCE. I WILL PROMPTLY PROVIDE THE INFORMATION NECESSARY TO PROCESS MY APPLICATION. FURTHERMORE, I WILL APPLY FOR ANY ASSISTANCE (MEDICAID, MEDICARE, INSURANCE, ETC) THAT MAY BE AVAILABLE TO ME FOR PAYMENT OF MY HOSPITAL CHARGES, I WILL PROVIDE INFORMATION AND TAKE ANY ACTION REASONABLY NECESSARY TO OBTAIN SUCH ASSISTANCE AND WILL ASSIGN OR PAY TO THE HOSPITAL, THE AMOUNT RECOVERED FOR THE HOSPITAL CHARGES.

IF ANY INFORMATION I HAVE GIVEN PROVES TO BE UNTRUE, I UNDERSTAND THAT THE HOSPITAL MAY RE-EVALUATE MY FINANCIAL STATUS AND I MAY BECOME LIABLE FOR MY HOSPITAL CHARGES.

LAST DATE EMPLOYED: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

FAMILY SIZE	ANNUAL INCOME	INCOME LAST 3 MONTHS

PLEASE INCLUDE VERIFICATION OF INCOME INFORMATION (I.E. COPIES OF W2 FORMS, FEDERAL INCOME TAX FORMS 2010 COPY OF YOUR LAST 3 MONTHS PAY STUBS 2010

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE: _____ **DATE:** _____

PLEASE MAIL INFORMATION TO : MAIN LINE HEALTH, 306 E. LANCASTER AVE., WYNNEWOOD, PA 19096