

Patient Name: _____ MRN: _____

Patient First Name: _____ Last Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Head of Household Name (if applicable): _____ Relationship to Patient: _____

Patient Home Phone: _____ Patient Cell Phone: _____

Patient Work Phone: _____ Patient Email: _____

Please confirm the address above. Please correct if needed.

Household Members*				
<i>Please provide the full name and date of birth for all members. Please include Social Security number and relationship.</i>				
Name <i>Full Name – First Name, MI, Last Name</i>	Date of Birth	Social Security Number	Relationship to Applicant	Applying Check if Yes
			SELF	<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>

*Relationship to Applicant should be the relationship of the Household Member to the applicant, not the Guarantor.
Examples would be wife, husband, daughter, son, mother, father, step-son, step-daughter, cousin, etc.*

*If more household members than those listed above, please see last page for extensions

Household Income*					
Please indicate if you or anyone in your household receives any of the following types of income:					
<input type="checkbox"/> Wages/Salary	<input type="checkbox"/> Alimony	<input type="checkbox"/> Veteran's Benefits			
<input type="checkbox"/> Self-Employed	<input type="checkbox"/> Unemployment Compensation	<input type="checkbox"/> Disability/Disability Benefits			
<input type="checkbox"/> Social Security	<input type="checkbox"/> Pension	<input type="checkbox"/> Workmen's Compensation			
<input type="checkbox"/> Child Support	<input type="checkbox"/> Real Estate/Rental Property Income	<input type="checkbox"/> Student I-20			
<i>Please provide the following information for all incomes you have indicated are received:</i>		<input type="checkbox"/> Other			
Household Member	Type <i>Provide Employer Name if Applicable.</i>	Amount	Period <i>Select one.</i>	Start Date	End Date <i>(If Applicable)</i>
			<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Annually <input type="checkbox"/> Hrly # hrs/wk _____		
			<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Annually <input type="checkbox"/> Hrly # hrs/wk _____		
			<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Annually <input type="checkbox"/> Hrly # hrs/wk _____		
			<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Annually <input type="checkbox"/> Hrly # hrs/wk _____		

*If more household income than those listed above, please see last page for extensions

For all household income received, you must provide supporting documents from the past 30 days in order to complete this application. (i.e., tax return, pay stubs, approval letter(s), self-employment schedules, child support statements, etc.)

 My household does not have any earned or unearned income

Assets/Resources*

Patient Name: _____ MRN: _____

Please indicate if you or anyone in your household receives any of the following resources:

- | | | |
|--|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Checking Account(s) | <input type="checkbox"/> CD(s) | <input type="checkbox"/> Mutual Funds |
| <input type="checkbox"/> Savings Account(s) | <input type="checkbox"/> Annuities | <input type="checkbox"/> Other |
| <input type="checkbox"/> Money Market Account(s) | <input type="checkbox"/> Bonds | |

Please provide the following information for all assets/resources indicated:

Household Member	Type	Account Number	Value

*If more assets/resources exist than those listed above, please see last page for extensions

For all asset(s)/resource(s) indicated, you must provide proof from the past 30 days.

 My household does not have any assets or resources to claim.

Other Information*

Please answer the following questions.

 Does patient have a permanent resident card for the United States? Yes No

 Does this household currently have public assistance? Yes No *If yes, provide the following:*

Insurance Company Name & ID number: _____

 Has patient applied for public assistance in the last 12 months? Yes No

 If yes, were you denied coverage Yes No

 Please attach approval/denial PA-162 letter. *(Received from the PA Dept. of Welfare)*

 Does patient have health insurance? Should you receive health insurance, please notify the department. Health Insurance is always primary over financial assistance. Yes No *If yes, provide the following:*

Insurance Company Name & ID number: _____

Insured's Name: _____ Birthdate: ____/____/____

*If more information to be noted than that listed above, please see last page for extensions

 Is the patient eligible for any of the following? Yes No

 Subsidized School Lunch Program

 Low Income Subsidized Housing

 State Funded Prescription Program

 WIC

 Food Stamps

If YES to any of the above, please provide documentation verifying eligibility

Signature

I affirm that the above information is true, complete, and correct to the best of my knowledge:

Applicant's Signature: _____ Date: _____

OR

Authorized Representative Signature: _____ Date: _____

Authorized Representative Name: _____ Relationship to Applicant: _____

Authorized Representative Phone #: _____ Cell #: _____

Patient Name: _____ MRN: _____

Household Members (continue)
Please provide the full name and date of birth for all members. Please include Social Security number and relationship if known.

Name <i>Full Name – First Name, MI, Last Name</i>	Date of Birth	Social Security Number	Relationship to Applicant	Applying Check if Yes
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>

Relationship to Applicant should be the relationship of the Household Member to the applicant, not the Guarantor. Examples would be wife, husband, daughter, son, mother, father, step-son, step-daughter, cousin, etc.

Household Income (continued)
Please provide the following information for all incomes you have indicated are received:

Household Member	Type <i>Provide Employer Name if Applicable.</i>	Amount	Period <i>Select one.</i>	Start Date	End Date <i>(If Applicable)</i>
			<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Annually <input type="checkbox"/> Hrly # hrs/wk _____		
			<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Annually <input type="checkbox"/> Hrly # hrs/wk _____		
			<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Annually <input type="checkbox"/> Hrly # hrs/wk _____		
			<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Annually <input type="checkbox"/> Hrly # hrs/wk _____		

☒ For all household income received, you must provide supporting documents from the past 30 days in order to complete this application. (i.e., tax return, pay stubs, approval letter(s), self-employment schedules, child support statements, etc.)

Assets/Resources (continued)
Please provide the following information for all incomes you have indicated are received:

Household Member	Type	Account Number	Value

☒ For all asset(s)/resource(s) indicated, you must provide proof from the past 30 days.

Other Information (continued)
Please answer the following questions.

Does patient have any additional health insurance? Should you receive health insurance, please notify the department. Health Insurance is always primary over financial assistance. Yes No *If yes, provide the following:*

Insurance Company Name & ID number: _____

Insured's Name: _____ Birthdate: ____ / ____ / ____