Monthly Household Income: Give monthly income for yourself and other household members. Also attach copies of your IRS Form 1040 and other proof of income documents (see documentation checklist).

	Self	Spouse and/or other household members		Self	Spouse and/or other household members
Wages/self-employment	$	$	Unemployment	$	$
Social Security	$	$	Workers' compensation	$	$
Pension or retirement income	$	$	Alimony and child support	$	$
Dividends and interest	$	$	Other income	$	$
Rents and royalties	$	$	Total Monthly Family Income	$	$

Available Household Resources: Attach copies of your household statements for the last month to this application.

Do you or other members of your household have a bank account? . . . . . ☐ Yes ☐ No

If **YES**, you must enclose the most recent monthly statement.

Check the types of accounts you have:

☐ Checking ☐ Savings ☐ Money Markets ☐ Certificates of Deposit (CDs)

☐ Health Savings Accounts (HSAs, FSAs, MSAs, HRAs)

Do you have any stocks, bonds, or other investments? . . . . . ☐ Yes ☐ No

Did you enclose copies of the most recent checking and savings bank statements?

Did you enclose copies of other statements (money market, CDs, stocks, bonds, all Health Savings accounts)?

Give information about your ownership of real estate (homes, property) and vehicles. Write zero for any of these items that you do not own.

Real Estate Value: **$**	Mortgage Balance: **$**	Monthly Payment: **$**
Other Property: **$**	Mortgage Balance: **$**	Monthly Payment: **$**
Motor Vehicle: ☐ Own ☐ Lease (check one)		
Make:	Model:	Year:
Motor Vehicle: ☐ Own ☐ Lease (check one)		
Make:	Model:	Year:

Monthly Household and Medical Expenses: Give information about the bills you pay every month.

Mortgage/Rent: **$**	Utilities: **$**	Real Estate Taxes: **$**	
Medical Bills (Please attach all Medical Bills): **$**	Prescriptions: **$**	Food: **$**	
Other bills, please describe: **$**			

Disclaimer: I understand that the information I provide will be used only to determine financial responsibility for my charges at Jefferson University Hospitals (does not include physician services), and will be kept confidential. I understand that the materials I send to prove my income and assets will not be returned. I further understand that the information which I submit concerning my annual family income and family size is subject to verification by Jefferson University Hospitals. I understand that my full cooperation with the Medical Assistance Application process and the Jefferson University Hospitals Financial Assistance application process is required to be considered for any benefits of this program. I understand that I will be financially liable for any charges for my medical services not covered through Charity Care. I understand that if any information I have given is determined to be false, it may result in reversing the Charity Care approval and I will be liable for the full amount of all charges.

My signature authorizes Jefferson University Hospitals to verify all information provided on this form. I certify that the above information is true and accurate to the best of my knowledge.

Signature: **X**	Relationship to Patient:	Date:

WHO CAN I CONTACT IF I HAVE ANY QUESTIONS OR NEED ASSISTANCE COMPLETING AN APPLICATION?
FINANCIAL COUNSELORS: 215-503-4489 OR 215-503-1178. LOCATED IN ADMISSIONS AT THE GIBBON BUILDING ON 10TH STREET BETWEEN CHESTNUT AND SANSOM STREET. CHARITY CARE DEPARTMENT: 215-955-3815

Jefferson®

Financial Assistance Application Information

Jefferson University Hospitals offers financial assistance for its medical care to eligible individuals and families. Based on your financial need, either reduced payments or Charity Care may be available.

You may be eligible for financial assistance if you:

- have limited or no health insurance
- are not eligible for government assistance (for example, Medicaid)
- can show you have financial need
- are a resident of Pennsylvania, New Jersey, or Delaware
- provide Jefferson with necessary information about your household finances

About the Application Process

The process for applying for Jefferson University Hospitals Charity Care Program includes these steps:

- Complete the Financial Assistance Application form in this packet.
  - ❖ Include supporting documents listed in the checklist.
  - ❖ We look at your income, assets (for example, bank accounts, stocks, bonds, and other investments), and family size to determine the level of assistance available to you. We use a sliding scale, based on federal poverty guidelines.
  - ❖ Note that you must first explore whether you are eligible for some type of insurance benefits that would cover your care (for example, workers' compensation, automobile insurance, and Medical Assistance). We can help direct you to the appropriate resources.
- We will contact you to tell you whether you are eligible for Jefferson's Charity Care Program.
- We can arrange a payment plan for any remaining charges or bills that are not covered by Charity Care.
- This Program is for your Jefferson Hospital charges only, and does not apply to physician services.

Filing Your Application

Please mail your completed application form and copies of your proof of income materials to:

Jefferson University Hospitals
P.O. Box 785992
Philadelphia, PA 19178-5992
Attn: Financial Assistance Representative

If you have any questions, please call 1-215-955-3815 to speak to a representative. Additional information is also available on the Web at *www.jeffersonhospital.org*. Select "Patient & Visitor Information" first, then "Patient Policies", and "Charity Care Program"

FORM 78727 (REV. 06/16)

Financial Assistance Documentation Checklist

Your application must include copies of any of the following documents that apply to you. Please attach copies, not originals, as Jefferson cannot return any documents sent with the application. If any of the documents are missing, it will delay processing of your application.

1. If You Have Income:

☐ Attach a copy of your most recent Internal Revenue Service (IRS) Form 1040, if you filed one.

If you did not file a federal income tax return, you must:

☐ state in writing that you are not required to file and the reason why (send this with your application)

☐ send us a copy of the most recent federal income tax return of anyone who claimed you as a dependent

Attach additional proof of your household income, which may include:

☐ Social Security 1099 forms or award letters

☐ unemployment or workers' compensation award letters

☐ Paystubs for last thirty days

☐ most recent IRS Form 1040 and appropriate schedules

☐ If you are self-employed, you must include a Schedule C and/or profit and loss statement.

2. If You Have No Income:

☐ If you have no income, send us a letter of support. The person who provides your support must sign the letter and have the document notarized.

3. Proof of Household Cash Available

Attach most recent statements for:

☐ checking and/or savings accounts

☐ stocks, bonds, certificates of deposit (CDs), high yielding interest accounts, or annuities

☐ any other investments, including real estate

☐ Health Savings Accounts (HSA), Medical Savings Accounts (MSA), Flexible Spending Arrangements (FSA), or Health Reimbursement Arrangements (HRA)

4. Letter of Denial of Medical Assistance

☐ Based on initial financial screening, you may need to apply for Medical Assistance and send a copy of your Letter of Denial before we can approve your application. Although financial assistance may be approved for future services, you may be required to complete a Medical Assistance Application at any time during the process.

5. Your Completed and Signed Financial Assistance Application Form

☐ Please make sure to complete all the parts of the form that apply to you.

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FINANCIAL ASSISTANCE APPLICATION FORM

Name of Patient:	
Patient's Date of Birth:	Patient's Social Security Number:
Address: Number and Street/City/State/Zip	
Daytime Phone Number:	Alternate Phone Number:
Employer's Name:	Spouse's Employer's Name:

If you have already received a bill, please give us your account number(s):

Household Information: List ALL members of your household who were claimed on your most recent IRS Form 1040.		
Names	Relation to Patient	Age

Total number of household members (including the patient):

Do you have health insurance: ☐ Yes ☐ No

If **YES**, please enclose a front and back copy of your insurance card(s).

Did you apply for Medical Assistance in the past 6 months? ☐ Yes ☐ No

If **YES**, please enclose a copy of the Letter of Denial or proof of eligibility.

If **NO**, please contact your local county assistance office for guidance on how to apply for these benefits.

Were these services related to an auto accident, Worker's Compensation, or any third party litigation? ☐ Yes ☐ No

If **YES**, please provide attorney and/or representative's name and contact information:

Name: _____

Address: _____

Phone Number: _____

Type of Case: _____

Are you 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**, please provide documentation verifying eligibility.

If you are eligible for any of the above programs, or are currently eligible for Medical Assistance, you are not required to complete the remaining pages of this application.

Please sign the application on the final page and forward with your attachments.