Mon Health℠ Medical Center

PO Box 1615, Morgantown, WV 26507 Phone: 304-598-1560

Date

Name
Address
City, State, Zip

RE: Account #

Dear

If you wish to be considered for financial assistance, please return the following documents within 60 days. A request for financial assistance can be made at any time during the billing/collection process.

FAILURE TO RETURN ALL THE REQUIRED DOCUMENTS MAY RESULT IN YOUR APPLICATION BEING DENIED.

1. A completed financial assistance application

2. Proof of family income:
    - Three most recent pay stubs, unemployment payment stubs, proof of social security and/or retirement income.
    - **If no income, please provide a signed statement from person or persons supporting you at this time.**

3. A copy of your most current completed tax return. If you did not file a return, please send a signed statement to that effect.

4. A copy of your Department of Health & Human Resources (Medicaid) denial letter.

5. A copy of your current checking and/or saving account statement, if applicable.

If you have any questions or require assistance in the completion of the application, please contact a customer service representative at (304) 598-1560.

I have enclosed a self-addressed, stamped envelope for your convenience.

Section A - Information Regarding the Patient

Full Name _____ Age _____

Social Security Number _____

Address _____ Years There _____

Telephone Number _____

Present Employer _____ Hire Date _____

Employer's Address

_____

Position or Title _____ Name of Supervisor _____ Phone Number _____

Present **Gross** Salary $_____ How Often _____

Other Income (Alimony, Child Support, Etc.) $ _____How Often _____

Source _____

Section B - Information Regarding Spouse of Responsible Party

Full Name _____ Age _____

Social Security Number _____

Address _____ Years There _____

Telephone Number _____

Present Employer _____ Hire Date _____

Employer's Address

_____

Position or Title _____ Name of Supervisor _____ Phone Number _____

Present **Gross** Salary $_____ How Often _____

Other Income (Alimony, Child Support, Etc.) $_____ How Often _____

Source _____

Section C - Dependent Children Living With You

Names	Relationship to Patient	Age	Occupation
1.			
2.			
3.			
4.			

5. _____

6. _____

Total annual income for your family $ _____

Section D - Financial Statement

Debt	Monthly Payment	Total Owed
❑ Rent ❑ Mortgage	$ _____	$ _____
Electricity	$ _____	$ _____
Gas	$ _____	$ _____
Water	$ _____	$ _____
Telephone	$ _____	$ _____
Other Utilities	$ _____	$ _____
Average Food Expense	$ _____	$ _____
Car, Life or Health Insurance Premiums	$ _____	$ _____
Short Term Loans	$ _____	$ _____
Charge and/or Credit Cards	$ _____	$ _____
Medical Bills	$ _____	$ _____
Other (Detail on separate sheet)	$ _____	$ _____

I hereby certify that the above information is true and correct to the best of my knowledge and further agree that any falsification or omission herein will disqualify me or my dependent(s) for financial assistance. I further agree that the above information given may be verified by Monongalia General Hospital.

_____ Initial for release of Financial Information to Radiology physicians.

_____ Initial for release of Financial Information to Anesthesiology physicians.

_____ Initial for release of Financial Information to the following physicians:

_____
SIGNATURE DATE