Grafton City Hospital Financial Assistance Application

Medical Record Number: _____ Applicant Name: _____
LAST FIRST MIDDLE INITIAL

Address:_____ City:_____ County:_____

State of Residence:_____ Zip Code:_____ Primary Phone ( ) _____

Marital Status: ❑ Single ❑ Married ❑ Divorced

Are you a US Citizen: ❑ Yes ❑ No If no, are you a legal resident of the United States: ❑ Yes ❑ No

Employer Name: _____

Address:_____

Secondary/Spouse Employer Name: _____Address:_____

Is Insurance offered through Employer: : ❑ Yes ❑ No If yes, provide cost of employee portion: _____

Did you have health insurance (other than Medicaid) at the time of your service?❑ Yes ❑ No If yes, please provide your insurance info and a copy of your insurance card

Name of Insurance: _____ Effective Date: _____/_____/____

Subscriber Name: _____ Subscriber ID: _____ Group #: _____

Have you applied for Medicaid coverage? ❑ Yes ❑ No If Yes, what is the status? ❑ Approved ❑ Pending ❑ Denied
Have you applied for coverage through the Healthcare.gov Insurance Marketplace? ❑ Yes ❑ No

SECTION TWO: FAMILY INCOME Please provide income for yourself, your spouse and all other household members

Monthly Income Source	Total Family Income for 1 month prior to date of service	Type of Income verification attached Proof of income is required to process your application
Wages/Self Employment/Tips	$	Copy of most recent federal tax return (or form 4506t), pay stubs for the last 30 days
Alimony/Child Support	$	
Food Stamps	$	
Retirement	$	
Unemployment	$	
Social Security	$	Social Security award letter
Pension, Dividends, Interest, Rental Income	$	Pension benefits letter, Dividend/Interest Statement
Unemployment, Workers' Compensation	$	Unemployment benefit letter, Workers' Compensation benefit letter
Rental Income	$	
Other: (explain)	$	

If you reported $0 income, please provide a brief explanation of how you (or the patient) are meeting basic living needs. Please also provide a letter of support from any individual assisting you: _____

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SECTION THREE: HOUSEHOLD MONTHLY EXPENSES

DESCRIPTION	Monthly Amount Paid	Verification Required
House/Rental Payment	$	
Car Payment	$	
Car Operating Expenses	$	
Phone/Cable	$	
Electric	$	
Gas	$	
Water	$	
City/Sewer	$	
Hospital and Physician Bills (Non-WVU Healthcare providers)	$	Copies of bills
Prescription Drugs	$	Pharmacy receipt print out
Other Medical Expenses	$	
Other: (explain)		

SECTION FOUR: FAMILY INFORMATION Please provide income for yourself and all other household members listed on your tax return

Name	Social Security	Relationship	Date of Birth	Applicant	Employed?
				Yes / No	Yes / No
				Yes / No	Yes / No
				Yes / No	Yes / No
				Yes / No	Yes / No
				Yes / No	Yes / No
				Yes / No	Yes / No
				Yes / No	Yes / No
				Yes / No	Yes / No
				Yes / No	Yes / No

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SECTION FIVE: ASSETS Please list all assets and their current value

Do You Have?	Circle Choice	Description	Total Current Value	Type of Verification Required
Checking Accounts (total balances)	Yes / No			Most current bank statement(s)
Savings Accounts (total balances)	Yes / No			Most current bank statement(s)
CD's/Stocks/Bonds	Yes / No			Most current investor statement(s)
Second Home (not your primary residence)	Yes / No			Tax assessment
Land	Yes / No			Tax assessment
Vehicles (Cars or Trucks)				Tax assessment
1.	Yes / No			
2.	Yes / No			
3.	Yes / No			
Camper/RV	Yes / No			Tax assessment
Other Recreational Vehicles (Boats/Motorcycles/ATVs)	Yes / No			Tax assessment
Other	Yes / No			Tax assessment

Please provide any additional information about assets listed above that you would like to have included in your application:

_____

By my signing below, I certify that everything I have stated on this application and on any attachments is true.

Responsible Party Signature: X_____ Date: _____

Return To:
Grafton City Hospital
Patient Financial Services
1 Hospital Plaze
Grafton, WV 26354
304-265-0400

Office Use Only

❑ Approved Due Date_____

❑ Denied Tracking Number_____