Allegheny Health Network (AHN) may be able to reduce or forgive an AHN bill for medically necessary services for patients who:

- Have no or limited medical insurance
- Have been denied Medicaid
- Are United States citizens
- Show financial need on the AHN Financial Assistance Application

Payment plans may also be available to help patients pay their AHN bills.

The patient or guarantor or representative must apply for financial assistance within 240 days of receiving the AHN bill. To apply:

- Obtain an AHN “Financial Assistance Application” form for each patient.
- Complete each patient's application within 30 days of receiving the form.
- Make copies of the “proofs of income” needed (see the list below).
- Send the signed application and copies of proofs of income to the address below for bills from:

  Allegheny Health Network (AHN)  
 Allegheny General Hospital  
 Allegheny Valley Hospital  
  AHN Brentwood Neighborhood Hospital  
  AHN Harmar Neighborhood Hospital  
  AHN Hempfield Neighborhood Hospital  
  AHN McCandless Neighborhood Hospital  

  AHN Revenue Cycle Operations  
  Financial Advocacy Department  
  4 Allegheny Center, 10th Floor  
  Pittsburgh, Pa 15212

  Canonsburg Hospital  
  Forbes Hospital  
  Grove City Medical Center  
  Jefferson Hospital  
  Saint Vincent Hospital  
  West Penn Hospital  
  Westfield Memorial Hospital  
  Wexford Hospital

“Proofs of income” documents:
Attach copies of these documents to the application (documents cannot returned):

- Copies of federal tax forms (IRS1040, etc.) for the past year
- For bank accounts, copies of all pages of the most recent statement
- For investment accounts, copies of all pages of the most recent statement
- For wages, copies of paystubs (for the past 30 days)
- For self-employment income, copies of Schedule C or profit/loss statements for the past month
- For other types of income, copies of proofs of income, such as:
  - Social Security 1099 form
  - Pension or other retirement income statement
  - Alimony, child/spousal support agreement
  - Rental or royalty income agreement
  - Veterans/disability award letter
  - Unemployment Compensation or Workers' Compensation award letter
- For patients with no income: Letter of support signed by person who provides support
- To show Medical Assistance denial: Copies of form PA-162 for all services denied (for PA residents only)
- Bankruptcy notices that impact dates of services being considered in addition to income information
- Proof of homelessness or residence at a homeless shelter

AHN will review the Financial Assistance Application promptly. AHN will send a letter if more information is needed. AHN must receive additional information within 30 days or the application will be denied.

AHN will notify the patient or the patient’s guarantor or representative of the decision in writing within 14 days of receiving the completed application. Any financial assistance provided applies to the current AHN bill(s) and may also apply to bills for medically necessary services for the next six (6) months.
Patient name: ____________________________________________________________ Birthdate: _____ / _____ / _____

(first, middle initial, last)

SSN: ______-____-__________

Home address: ____________________________________________________________

(number and street, apt. no. city state zip code)

Phones: Day________________________________ Other________________________________

Employer name: ____________________________________________________________ Phone: __________

Marital status: □ Married □ Divorced □ Separated □ Widowed □ Single

Spouse/Guarantor Name: ____________________________________________ Relationship to patient: __________

Guarantor address: ____________________________________________________________

(number and street, apt. no. city state zip code)

Guarantor phones: Day________________________________ Other________________________________

Household members: List all in the patient’s household who are claimed on IRS form 1040

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to patient</th>
<th>Age</th>
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<tbody>
<tr>
<td>______________________</td>
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Home: Please check, patient/guarantor: □ Owns home □ Rents home □ No home

The following asset information not required for Westfield Memorial Hospital.

If home is owned, please list:

Assessed value: $________ Amount still owed on mortgage: $________

If patient/guarantor has an interest in other real estate, please list:

Address: ____________________________________________________________

(number and street city state zip code)

Names of co-owners:

Assessed value: $________ Amount still owed on mortgage: $________

Motor vehicles: Please list make, model and year of each motor vehicle:

____________________________________________________________________ □ Owned □ Lease

____________________________________________________________________ □ Owned □ Lease

Bank accounts: Please list the following information and attach 2 months of statements for each bank account such as checking, savings, certificates of deposit (CDs), money market, etc.

<table>
<thead>
<tr>
<th>Account type</th>
<th>Bank or financial institution name</th>
<th>Account no.</th>
<th>Current balance</th>
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</thead>
<tbody>
<tr>
<td>____________</td>
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Investments: Please list the following information and attach 2 months of statements for each investment, such as stocks, bonds, mutual funds, etc.

<table>
<thead>
<tr>
<th>Investment type</th>
<th>Bank or financial institution name</th>
<th>Current value</th>
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<tbody>
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</table>
**Total household monthly income**: Include the total for the household (patient and all others) for all income, including wages, Social Security, pension or other retirement income, alimony, child/spousal support, rent/royalty/self-employment income, veterans/disability payments, unemployment compensation, worker compensation and investment (interest, dividend) income. Proof of income must be supplied as listed on the instruction page.

Total household wages: $ ______________ Total worker comp: $ ______________
Total Social Security: $ ______________ Total alimony/child support: $ ______________
Total pension, other retirement: $ ______________ Total other income (please describe):
Total rent/royalty income: $ ______________
Total dividends and interest: $ ______________
Total unemployment income: $ ______________

**Expenses**: Please list household monthly expenses for:

Mortgage or rent: $ ______________ Prescriptions: $ ______________
Real estate taxes: $ ______________ Medical supplies: $ ______________
Utilities: $ ______________ Other AHN bills: $ ______________
Motor vehicle payment: $ ______________ Other expenses (please describe):
Motor vehicle insurance: $ ______________
Food: $ ______________

**Other information**

Have you applied for Medical Assistance?  ❑ No  ❑ Yes (If yes, please provide copies of your application and the determination letter)

Are you a citizen of the United States?  ❑ No  ❑ Yes

Did you have health insurance at the time of your treatment?  ❑ No  ❑ Yes

**Authorization and verification**

I, ____________________________, attest that the information provided in this form is true and correct to the best of my knowledge. I understand that this form and the proofs of my income and expenses will not be returned. I authorize Allegheny Health Network to verify the information and to ask for a credit rating, if needed, to decide if I am eligible for financial assistance. I understand that if any information is found to be false, I may be denied financial assistance, may be solely responsible to pay my bill in full, and may not be eligible for future financial assistance. I understand that my eligibility for financial assistance may be re-evaluated for subsequent hospital services.

Patient or representative / guarantor signature ____________________________ Date ______________

Print patient or representative/guarantor name ____________________________

Relationship to patient: ____________________________