Financial Assistance Application

Westfield Memorial Hospital (WMH) may be able to reduce or forgive a WMH bill for medically necessary services for patients who:

- Have no or limited medical insurance
- Do not qualify for Medicare
- Have been or may be denied Medicaid
- Are United States citizens and residents of the Westfield New York service area of Chautauqua County
- Show financial need on the WMH Financial Assistance Application

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

The patient or guarantor or representative must apply for financial assistance within 120 days of receiving the WMH bill. To apply:

- Obtain a WMH "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:

Westfield Memorial Hospital
Patient Accounting Customer Service
232 West 25 Street
Erie, PA 16544
1-866-793-1430.

"Proofs of income" documents:
Please note WMH will not use an asset test to determine financial assistance

Attach copies of these documents to the application (documents cannot be returned)

- **Copies** of federal tax forms (IRS1040, etc.) for the past 2 years, if available
- For bank accounts, **copies** of all pages of the 2 most recent statements (may be provided, but not required)
- For investment accounts, **copies** of all pages of the 2 most recent statements (may be provided, but not required)
- For wages, **copies** of most recent 3 months' payment cycles
- For self-employment income, **copies** of Schedule C or profit / loss statements for the past 3 months
- 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 forms for all services denied (may be provided, but not required)
- Bankruptcy notices that impact dates of service being considered, in addition to income information
- Proof of homelessness or residence at a homelessness shelter
- Any financial assistance provided applies to current Westfield Memorial Hospital bills and may also apply to medically necessary services for the next six (6) months.

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

WMH will notify the patient or the patient's guarantor or representative of the decision in writing within 14 days of receiving the **completed** application.

You do not have to make any payments to the hospital until the hospital sends you a letter with its decision on your application.

WESTFIELD MEMORIAL HOSPITAL

Financial Assistance Application

Patient name:_____ **Birthdate:**_____/_____/_____
(first, middle initial, last)

SSN:_____-_____-_____*Optional*

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*

Name	Relationship to patient	Age

Home: *Please check, patient/guarantor:* ___Owns home ___Rents home ____ No Home

THE FOLLOWING ASSET INFORMATION MAY BE PROVIDED BUT NOT REQUIRED

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.*

Account type	Bank or financial institution name	Account no.	Current balance
			$
			$
			$

Investments: *Please list the following information and attach 2 months of statements for each investment, such as stocks, bonds, mutual funds, etc.*

Investment type	Bank or financial institution name	Current value
		$
		$

WESTFIELD MEMORIAL HOSPITAL

Financial Assistance Application

THE FOLLOWING INFORMATION IS REQUIRED TO PROCESS YOUR APPLICATION

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 WMH 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 and a resident of the Westfield New York service area of Chautauqua County, ?

__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 Westfield Memorial Hospital 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: _____