Allegheny Health Network

Instructions for Financial Assistance Application

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 General Hospital
Allegheny Valley Hospital
Canonsburg Hospital
Forbes Hospital
Jefferson Hospital
Saint Vincent Hospital
Saint Vincent Hospital
West Penn Hospital
Westfield Memorial Hospital
Allegheny Health Network

AHN Revenue Cycle Operations
Customer Care Center
4 Allegheny Center, 4th floor
Pittsburgh, PA 15212

"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.

Allegheny Health Network

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*

Name	Relationship to patient	Age

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.*

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
		$
		$

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: _____