Return form to:
PO Box 16052, Reading, PA 19612-6052
Please call: 484-628-7400 or
833-321-7327

APPLICATION FOR PATIENT FINANCIAL ASSISTANCE

Name: _____Last 4 digits of Social Security #:_____ Date of Birth: _____

Current Address: _____
NUMBER & STREET CITY STATE ZIP

Home Telephone:_____ Cell Phone: _____

Previous Address if you have lived at
Current Address less than 2 years: _____
NUMBER & STREET CITY STATE ZIP

Do you rent or own your Home? ❑ Own ❑ Rent

Are you and/or any immediate family member residing in your household currently employed? ❑ Yes ❑ No
If YES, list the name of the person employed and his/her employer. Please remember to include yourself.

_____ _____
Name Employer

_____ _____
Name Employer

_____ _____
Name Employer

If YES, is medical insurance available to you through any of these employers? ❑ Yes ❑ No
Are you covered under any other person's medical insurance? ❑ Yes ❑ No
If you do not work, how long have you been unemployed? _____
Please list names of people who live in your house, their relationship, and dates of birth

_____ _____ _____
Name Relationship Date of Birth

_____ _____ _____
Name Relationship Date of Birth

_____ _____ _____
Name Relationship Date of Birth

Please attach the following for each household member. If unable to supply, please indicate the reason:
1. 1 Month of Pay Stubs:
2. Unemployment Compensation Check Stubs:
3. Income Tax return (Signed & Most Recent Year) including W-2 Withholding Statement:
4. DPA/MA Denial/Rejection: (web link for MA application: www.compass.state.pa.us)
5. Disbursement letter from Social Security Office for annual income verification.

Patient's Gross Annual Income:	$ _____
Other Family Income:	+$ _____
Total Family Income:	$ _____

I acknowledge that the information provided is true and correct. I authorize the facility to verify any information contained in this document for the sole purpose of assessing financial need.

I understand that if my financial situation or availability of resources changes, I am required to notify the facility of the change for the purpose of being reassessed for this program.

_____ _____
Signature of Patient Date

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