LEVI HOSPITAL

Dear Patient,

Please find attached the Financial Assistance Application. If you have no income to report on the Application, please fill out the Statement of Zero Income. Also include the last 2 years of tax returns with your application. This information must be returned to Levi Business Office for consideration.

Please note, you must have first filed for Medicaid to be eligible for Financial Assistance. Please provide either your Medicaid number or proof of denial along with your application.

While Levi is happy to assist you with financial aid, please keep in mind that all applications will not be approved. Approvals will only be granted by the guidelines of the policy in place.

Thank you,

Levi Business Office

Application for Financial Assistance

LEVI HOSPITAL

Applicant Name: _____ DOB: _____ SSN: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Employer: _____ Occupation: _____

Employer Address: _____

Have you applied for Medical Assistance (i.e., Medicaid) Y N If Yes, what date? _____

INCOME

Wages/Salaries	$ _____
Social Security	$ _____
Pensions	$ _____
Disability/SSI	$ _____
Unemployment	$ _____
Workers Comp	$ _____
Child/Spousal Support	$ _____
VA Benefits	$ _____
Public Assistance	$ _____
Total Monthly Income	$ _____
Total Annual Income	$ _____

EXPENSES

Mortgage/Rent	$ _____
Property Taxes	$ _____
Insurance	$ _____
Autombile	$ _____
Credit Cards (TOTAL)	$ _____
Utilities (water,gas,electric)	$ _____
Phone	$ _____
Child/Spousal Support	$ _____
Other	$ _____
Total Monthly Expenses	$ _____

HOUSEHOLD MEMBERS

NAME	RELATION/AGE
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____
6 _____	_____

HOUSEHOLD COUNTABLE RESOURCE (LIQUID ASSETS)

Checking Account	$ _____
Savings Account	$ _____
Health Savings Account	$ _____
Other (Please explain)	$ _____

I certify that the information contained in this application is true and complete. I undertand that willful falsification of information contained in this application will result in denial of my application for financial assistance. I am aware that the information provided is subject to verification by Levi Hospital.

X _____

Date _____

**Please include the two most current years of tax returns with your application

Attachment A

LEVI HOSPITAL

STATEMENT OF ZERO INCOME

To be completed by an Applicant whose household has had no income for the past 30 days.

I, _____, state that no member of my household has received any source of income during the past 30 days.

Our household has been without income since _____. I hope and expect to receive some income on or about _____ from _____.

During the above period, how did your family meet their household needs for:

Food:

_____

_____

_____

Housing and utilities:

_____

_____

_____

Living expense: (medical bills, car expenses, clothing)

_____

_____

_____

I understand that I can be denied financial assistance for making false statements. By signing below, I am stating that all information provided above is true.

Applicant signature: _____ Date: _____

Patient Financial Services
Representative Signature: _____ Date: _____