

**WEST PENN ALLEGHENY HEALTH SYSTEM, INC.
ACCOUNT ASSISTANCE APPLICATION**

The information you provide in this form will enable the WPAHS to determine your ability to pay for the medical services that have been or will be provided to you. It will also be used to determine your eligibility for assistance with the payment of your account from WPAHS. The information you provide will be kept confidential and will only be shared with WPAHS employees, agents or business associates in connection with the determination of your ability to pay for the charges, a determination of your eligibility for account assistance and for the purpose of securing payment for the services provided.

FACILITY: _____ **DATE (app provided):** _____

A. PATIENT AND HOUSEHOLD INFORMATION

PATIENT NAME: _____ **BIRTH DATE:** __/__/____
(first, last, middle initial)

PATIENT NUMBER: _____ **SS#:** _____

Address: _____ **Day Time Phone.:** () _____
 _____ **Cell Phone.:** () _____
 _____ **Night Phone.:** () _____

Employed: Yes ___ No ___

Employer Name: _____ **Employer Phone.:** () _____
Address: _____ **Position:** _____

Gross Monthly Wages: \$ _____ **Other Monthly Income:** \$ _____
 (Please provide copy of last 3 months pay stubs) **Source** _____

Marital Status: Married ___ Single ___ Divorced ___ Separated ___ Widowed ___

Spouse/Guarantor Name: _____ **Home Ph.:** (____) _____

Address: _____ **Employed:** Yes ___ No ___

Employer Name: _____ **Ph.:** (____) _____
Address: _____
Position: _____

Gross Monthly Wages: \$ _____ **Other Monthly Income:** \$ _____
 (Please provide copy of last 3 months pay stubs)

Total Household Monthly Income: \$ _____.

("Income" includes wages, alimony, child or spousal support, social security, veterans or other disability payments, workers compensation, unemployment compensation, rental income, income from self-employment and pension or retirement income.) Please provide copies of any documents showing the amount and frequency of payment of other income. Self-employed persons must show profit and loss for prior three months.

Total Number of dependents including self: _____.

Do you own a business? Yes ___ No ___ **Name & Address:** _____

B. ASSETS

Monthly Mortgage:\$_____ Monthly Rent:\$_____

Assessed Value of your home?_____ Amount Still owing?_____

Do you own or have interest in other real estate? Yes_____ No_____

If yes, please provide:

Property Address:_____ Co-owners:_____

Assessed Value: \$_____ Amount of Mortgage Owed:\$_____
(if additional space is needed, please include on back of page.)

Make, model and year of car(s):_____

**Checking, Saving or Other Accounts: Please attach supporting documentation.
(Including: IRA, 401 k, Certificates of Deposit, Mutual Funds, and Money Market)**

Type	Name of Bank/ Financial Institution	Account Number	Current Balance
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

Do you own stocks, bonds or any other investment? Yes_____ No_____

If yes: Type:_____ Value:_____

Type:_____ Value:_____

Type:_____ Value:_____

Type:_____ Value:_____

C. LIABILITIES

Monthly Expenses:

Mortgage (or rent, if applicable): \$ _____
 Utilities \$ _____
 Auto Payments \$ _____
 Insurance \$ _____
 Child or Spousal Support \$ _____
 Credit Card Payments \$ _____
 College Tuition \$ _____
 Medication/Health Care Supplies \$ _____
 \$ _____
 Other Health Care Bills within our System \$ _____
 (incurred at AGH, AKMC, CGH, FRH, WPH or SGH or physicians within our system)
 Other (please list) \$ _____
 \$ _____
 \$ _____

D. TAX INFORMATION

Please include last 2 years of complete tax information (1040 forms and any other supporting documentation.)

E. OTHER INFORMATION

Have you applied for Medical Assistance? Yes _____ No _____ Date: _____
(If yes, please provide copies of application and of determination)

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

If no, do you have an application for citizenship pending? Yes _____ No _____

Does your employer offer health insurance coverage? Yes _____ No _____
**If yes, why didn't you purchase coverage? _____

Are you able to purchase insurance now? _____ If so, when? _____

If you recently separated from your employer within the last 60 days, did you elect COBRA benefits? _____

*If yes, please contact Customer Service immediately in order to provide your information.

*If no, please contact your employer to obtain written documentation regarding COBRA eligibility and contact Customer Service immediately with this information, we may be able to assist you.

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

If yes, please provide insurance company name and ID number:

<i>Company name</i>	<i>I.D. Number</i>	<i>Group Number</i>

Effective Date: _____

F. AUTHORIZATION AND VERIFICATION

I, _____, hereby verify that the information provided for in this form is true and correct to the best of my knowledge, information and belief. I authorize the West Penn Allegheny Health System to make any investigation necessary to verify my eligibility for financial assistance with my account including credit rating inquiry when necessary. I understand that falsification of this information may result in a denial of any request for assistance and my being solely responsible for the full charges for the services provided to me and may also affect my eligibility for future financial assistance. I further understand that my eligibility for financial assistance from the hospital may be re-evaluated for each subsequent hospital service. If the assistance is in the form of a payment arrangement, I understand that failure to make the required payment may result in termination of the payment arrangement and in my responsibility for the immediate payment of the account balance.

Date: _____

Patient or Patient Representative Signature

Name of Representative

Relationship to the Patient

PLEASE RETURN THIS FORM AND THE DOCUMENTS REQUESTED TO THE FINANCIAL COUNSELOR IMMEDIATELY. ANY CHANGES IN YOUR FINANCIAL SITUATION SHOULD BE REPORTED AS THEY MAY AFFECT YOUR ELIGIBILITY. After your eligibility is determined, you will be advised as to the type of assistance that is available to you.

You may also mail this completed application with attachments to:

For Allegheny General Hospital & Suburban Campus and West Penn Hospital & Forbes Regional Campus applications to:

**Patient Financial Services
Two Allegheny Center, 13th
PGH, PA 15212
Attn: Linda Buckner, Team Leader**

For CGH applications to:

**Patient Financial Services
100 Medical Blvd
Canonsburg, PA 15317
Attn: Credit Department**

For AKMC applications to:

**Patient Financial Services
1301 Carlisle Street
Natrona Heights, PA 15065-9989
Attn: Credit Department**

G. PAYMENT ARRANGEMENT FORM

(Monthly payment arrangement, please complete this section)

Hospital Account #: _____ Account Balance/s:\$ _____
_____, _____

Dates of Service: _____ Proposed Payment:\$ _____

Number of Payments: \$ _____ (Please note: Interest free payments may not extend beyond six (6) months for total or combined account balances less than \$450.00 or twelve (12) months for balances greater than \$900.00 from the date of the approval of the request for monthly payments. The minimum monthly payment must be \$75.00 or more if balance is greater than \$900 or 1/12th of the amount due).

Do you want to use your credit card to pay the balance due? Yes _____ No _____

If yes: Card: MC _____ VISA _____ Discover _____ American Express _____

Card #: _____ - _____ - _____ - _____ Expiration: _____ / _____ / _____

Authorization to Charge Card in the amount of \$ _____.

Signature of Cardholder

Date

A Payment Installment Letter will be sent to you or someone will contact you upon receipt of this information to review and confirm your monthly payment agreement.

If you are interested in paying on-line via internet access our website at: wpahs.org

For further assistance please call our Customer Service Areas:

**Allegheny General Hospital, Suburban Campus, West Penn Hospital and Forbes Regional Campus
1-800-547-0540**

**Alle-Kiski Medical Center
724-226-7054**

**Canonsburg General Hospital
724-746-6311**

Internal Use Only

This page to be used by the A/R Department to set up installments in the patient account, Cash Applications to post the payments listed and Optical Imaging into the patient's electronic folder.