



Keystone Health

Leading the Way to a Healthier Community

Financial Assistance Application for Keystone Health

Home Address: _____

Phone Number: Home _____ Cell _____ Best Time to Call? _____

Household Members – (include only household dependents)**List additional names on back

Office Use Only

Name:	Relationship:	Date of Birth:	Employed Y/N	Person#	M	D
1. _____	Self	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____	_____

Monthly Gross Household Income Received:

***Information only required if applying for Summit Care Program*

Wages/Salaries (before taxes): _____ Pensions/Annuities: _____

Social Security: _____ Other Disability: _____

SSI/SSDI: _____ **Cash Assistance: _____

Unemployment Compensation: _____ **Veteran's Administration (VA) Benefits: _____

Child Support: _____ **Workman's Compensation: _____

Spousal Support: _____ Interest and Dividends: _____

Other Income: _____

Household Resources:

***Information only required if applying for Summit Care Program*

Checking Account(s): _____ Savings Account(s): _____

**Christmas/Vacation Club: _____ **Stocks or Bonds: _____

**Certificates of deposit: _____ **Money Markets accounts: _____

**Trust Funds: _____ **US Savings Bonds: _____

For your application to be processed, the following information must be returned along with this form:

- Checking and Savings account statements showing detailed activity from the previous month (individual and business). Statements must show financial institution name and customer account name and number.
- Pay stubs or letter from employer listing wages before taxes for last 3 months.
- Proof of all other monthly gross household income received during the year.

Have you applied for Medical Assistance in the past 90 days? Yes / No **If yes**, date applied: _____ **If no**, please notate back of application. Navigators Initials: _____

Do we have your permission to share information contained in this application with other health care providers for them to determine financial assistance eligibility for their services? Yes / No

I certify that the information provided on this application is true and complete and may be checked for accuracy. I understand that willful falsification and/or omission of information contained in this application will result in denial of financial assistance.

Requestor's Signature: _____ **Date:** _____

If you have any questions, please call us for help: **Keystone Health Outreach Enrollment 717-709-7969**

Office Use Only

Account# _____

Guarantor: _____

Approved Date: _____

Approved By: _____

Discount%: _____

Expiration Date: _____

Denied Date: _____

Denial Reason: _____ Over Income _____ Did not receive all documentation

Income: _____

Processor: _____ Date: _____

RF Primary: _____

RF Secondary: _____

What is Primary Insurance: _____

Deductible/Co-insurance: _____

NAVIGATOR COMMENTS:

Did Navigator Assist Patient in Applying for Medical Insurance? YES/NO

If so, what plan: _____MA _____CHIP _____MP

If not, why: _____

Card made by: _____

Card scanned in Nextgen by: _____

Discounts applied in Medical by: _____

Forwarded to Dental and discounts applied: _____

Added to spreadsheet by: _____