Keystone Health

Leading the Way to a Healthier Community

Financial Assistance Application for Keystone Health

Patient Name: _____ Date of Birth: _____

Home Address: _____

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

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

	Name:	Relationship:	Date of Birth:	Employed Y/N	Insurance Y/N	Account#
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#_____

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: _____