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***

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

Monthly Gross Household Income Received:

Wages/Salaries/Tips (before taxes): ____________________

Social Security: ____________________

SSDI: ____________________

Unemployment Compensation: ____________________

Alimony (Spousal support): ____________________

Pension and Annuities:____________________

Interest and Dividends:____________________

Other Income (including rental properties): ____________________

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

**Cash Assistance: ____________________

**Veteran's Administration (VA) Benefits: __________

**Workman's Compensation____________________

Household Resources:

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

Checking Account(s): ____________________

**Christmas/Vacation Club:____________________

**Certificates of deposit:____________________

**Trust Funds: ____________________

Savings Account(s): ____________________

**Stocks or Bonds:____________________

**Money Markets accounts:____________________

**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 2 months (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 up to 2 months of pay (For Summit 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:____

Scale :_______________________________ 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: __________________________

04/01/19