



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 taxable household/ dependents)List additional names on back Office Use Only**

| Name: | Relationship: | Date of Birth: | Employed Y/N | MRN# | M | D | BH |
|----------|---------------|----------------|-----------------|-------|-------|-------|-------|
| 1. _____ | Self | _____ | _____ | _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 5. _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 6. _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 7. _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 8. _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

Monthly Gross Household Income Received:

Wages/Salaries/Tips (before taxes): _____

Social Security: _____

Self-employment business income: _____

Unemployment Compensation: _____

Alimony (Spousal support): _____

Pension and Annuities: _____

Other Income/investment (including rental properties): _____

Household Resources:

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

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
- 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: _____

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 Practice Management System by: _____

Discounts applied in Medical by: _____

Forwarded to Dental and discounts applied: _____

Added to spreadsheet by: _____