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 if applicable:

- 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: _____

6_1_25 SMS