Financial Assistance
Application Form

As part of our mission to *improve the health of the communities we serve, one patient at a time*, Preston Memorial Hospital elects to provide financial assistance to individuals who are unable to pay for healthcare services. Individuals meeting the eligibility requirements, outlined in our *Financial Assistance Policy*, will be granted some level of financial assistance, per our sliding fee scale, for medically-necessary services performed by Preston Memorial Hospital providers.

Application Requirements Checklist:
The following is a general list of application requirements, as outlined in our Financial Assistance Policy. Please ensure that all areas are answered to the best of your ability and knowledge. Please contact our Financial Counseling Office at 304-329-2830 for any specific questions or to speak to a helpful representative. Feel free to include and attach additional paper if there is any other information you wish us to consider.

Overall Patient Information

- ☐ Have I completed the attached, standard, Financial Assistance Application form completely?
- ☐ Have I applied for Medicaid coverage?
- ☐ If denied - have I supplied the required Medicaid / (Medical Assistance) denial documentation?
- ☐ Is that Medicaid / (Medical Assistance) application dated within the last 90 days?

Patient Financial and Family Information

- ☐ Have I provided documented proof of ALL family income? (as documented on page 2)
- ☐ Have I provided the most recent income tax return(s)?
- ☐ Have I provided detailed listing of family members and size of family? (as documented on page 3)
- ☐ Have I provided proof of mortgage or living expenses? (as documented on page 3)

Preston Memorial Hospital has elected to offer this opportunity to apply for financial assistance for your hospital medical bill(s). In order for us to review your information, this application (and all pages and supporting documents) must be completed in its entirety. The form, and all listed documentation, must be returned to the Hospital within 30 days. Failure to return all required documents may result in your application being denied for financial assistance.

Direct all questions to the Financial Counseling Office at 304-329-2830, Monday through Friday 8:00 AM – 4:00 PM.

Please provide the information requested to the following address:

Preston Memorial Hospital
Financial Counseling Office
150 Memorial Drive
Kingwood, WV 26537

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SECTION I - Patient Information

Account Number: ______________________ Applicant Name: ____

Address: ____ City: _________________________ State: ________

County of Residence: __________________ Zip Code: ___________ Primary Phone: ( ) ___________________

Did you have health insurance (other than Medicaid) at time of service? **__Yes __ No** *If yes, please provide insurance info.*

Have you applied for Medicaid Coverage? **__Yes __ No** If YES, what is the status? **__Approved __Pending __Denied**

Have you applied for coverage through the Healthcare.gov Insurance Marketplace? **__Yes __ No**

SECTION II - Family Income

Please provide TOTAL income for yourself and all other household/family members:

Monthly Income Source	Total Family Income for 1-Month	Type of income verification (Proof) required to process your application
Wages / Self Employment	$	Copy of most-recent tax return & pay stubs for the last 30 days.
Social Security	$	Social Security award letter
Pension, Dividends, Interest, rental Income	$	Pension benefits letter, Dividend/Interest statements
Unemployment, Workers' Compensation	$	Unemployment benefit or Workers' Compensation benefit letter(s)
Other income	$	Documentation or statement to support income
TOTAL MONTHLY INCOME	$	Should represent all family income for 1-month

If you reported $0 in income, please describe a brief explanation of how you (or the patient) are meeting basic living needs. Please also provide a letter of support from any individual(s) assisting you:

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Account Number: ______________________ Applicant Name: ____

SECTION III - Family Information

Please identify all members of your family or household:

Name	Relationship	Social Security	Date of Birth	Applicant?	Employed?
				Yes / No	Yes / No
				Yes / No	Yes / No
				Yes / No	Yes / No
				Yes / No	Yes / No
				Yes / No	Yes / No
				Yes / No	Yes / No

TOTAL Members Identified: ___________________

SECTION IV - Banking and Asset Information

For sliding scale discount-eligible individuals, only family income and family size are considered for discount; asset information is used to help confirm and evaluate income level.

Account Type	Description	Current Value	Type of Verification
Checking Account(s)		**$**	Must current bank statement(s)
Savings Account(s)		**$**	Most current bank statement(s)
CDs / Stocks / Bonds		**$**	Most current investor statements(s)
Mortgage/Rent		**$**	Mortgage statement or agreement
Other (list)		**$**	Written documentation

By my signing below, I certify that everything I have stated on this application, and on any attachment, is true and accurate.

Responsible Party Signature: X ____ Date: __________________

Please return entire, signed application to the following address:

Preston Memorial Hospital
Financial Counseling Office
150 Memorial Drive
Kingwood, WV 26537

For Office Use Only

Date Sent: __________________________

Rep: _______________________________

Mon Health
Preston Memorial Hospital

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Sliding Fee Schedule

The following is provided as a guide based on recently available public information. The most-current Poverty Guidelines published by the Department of Health and Human Services will always be used in the final evaluation of any financial assistance granted.

Family Size:	If Annual Income is less than (for family size on the left):		
1	$ 17,864	$ 22,330	$ 25,520
2	$ 24,136	$ 30,170	$ 34,480
3	$ 30,408	$ 38,010	$ 43,440
4	$ 36,680	$ 45,850	$ 52,400
5	$ 42,952	$ 53,690	$ 61,360
6	$ 49,224	$ 61,530	$ 70,320
7	$ 55,496	$ 69,370	$ 79,280
8	$ 61,768	$ 77,210	$ 88,240
You may be entitled to the following financial assistance:			
Discount %:	**100%**	**75%**	**50%**

This schedule has been updated using the guidelines, as published, on Friday January 31, 2020 in the Federal Register. For updated copies, please refer to our website, www.prestonmemorial.org, or contact a member of the Hospital's Financial Counseling team.

If family income falls between the amounts listed in the columns above, the account will be discounted by the percentage indicated. All amounts are derived from the Federal Poverty Guidelines as published by the Department of Health and Human Services. The tiers are outlined in Preston Memorial Hospital's *Financial Assistance Policy*.

For further questions, concerns, or assistance with this application, please contact a member of our Financial Counseling team at 304-329-2830 between 8:00AM-4:00PM, Monday through Friday.