Preston Memorial Hospital
Mon Health System

Financial Counseling Office
300 South Price Street
Kingwood WV 26537
(304) 329-4719

Application for Financial Assistance

Date: _____ Account No.: _____ Date of Service: _____

Account No.: _____ Date of Service: _____

Patient Name: _____ Guarantor Name: _____

Relationship of Guarantor to Patient: _____

Address: _____ Phone: _____

_____

City State Zip

Alternate Contact/Relative: _____ Phone: _____

SOURCE OF ALL HOUSEHOLD INCOME

	Patient Gross Income	Guarantor Gross Income
1. Employer_____	**$**_____	**$**_____
Employer_____	**$**_____	**$**_____
2. Other income (List all household income: include self employment and rental income)		
A._____	**$**_____	**$**_____
B._____	**$**_____	**$**_____
Total Monthly Gross Income	**$**_____	**$**_____

If no income is listed, how do you live? _____

_____

_____

BANKING (Savings, Checking, Mortgage, Other)				
Bank/Credit Union	**Address**	**Account No**	**Balance**	**Name on Account**

Preston Memorial Hospital
Mon Health System

Do you have any insurer or other resources to pay for these services? Yes_____ No_____
If another resource is responsible for payment, please list name, address, telephone number and contact person:

_____

_____

Date applied for Public Assistance, Medicare, other: _____ Approved_____ Denied_____
Have you ever filed bankruptcy? No_____ Yes_____
Number of people in your household_____ Please identify below:

Name	Relationship	SS#	DOB	Employer	Weekly Income

Preston Memorial Hospital is offering you the opportunity to qualify for financial assistance for your hospital medical bill(s). In order for us to review your financial status, this Financial Statement must be completed and the following information provided. This form and all listed information must be returned to us within 15 days. If your account has been placed with a collection agency, we will be unable to assist you.

1. **Proof of Income** (pay stub showing current and year to date income). Child Support, rental income and self employed income must be verified by appropriate supporting documents.
2. **Rent, mortgage receipt or canceled check.**
3. **Copy of last year's income tax return.**
4. **Proof of approval or denial for Medicaid.**
5. **If any of the above does not apply, provide all details in letter form with your statement notarized. Attach to this document and return.**

If you need assistance or clarification, please call the Financial Counseling Office Monday through Thursday 7:30a.m. – 6:00p.m. (304) 329-4719.

All information provided on this application is correct to the best of my knowledge. Preston Memorial Hospital is authorized to check my credit and employment history to obtain information regarding my application for financial assistance.

Patient _____ Date_____

Guarantor_____ Date_____

Financial Assistance programs at Preston Memorial Hospital are applicable to residents of West Virginia for Basic Medically Necessary Hospital Services and do not apply to services not billed by Preston Memorial Hospital.

INTERNAL USE ONLY

Date sent_____ Representative_____