GROVE CITY HEALTH SYSTEM
APPLICATION FOR FINANCIAL ASSISTANCE
GROVE CITY MEDICAL CENTER AND WOLF CREEK MEDICAL ASSOCIATES*
---APPLICATION INSTRUCTIONS---

Dear Applicant:

Grove City Health System recognizes that services may be provided to persons who may have difficulty paying. The Financial Assistance Program may be of help. To apply, you must complete an application and provide proof of your income. A single application is used for services provided by Grove City Medical Center and Wolf Creek Medical Associates.

If you are uninsured and your outstanding medical bill balance(s) exceed $1,000, you must apply for Medical Assistance for the applicable dates of service. An application may be requested from the business office or you may apply on-line at www.compass.state.pa.us. If you have applied for Medical Assistance and been denied, send a copy of the denial with your financial assistance application.

If you are underinsured, financial assistance is available for the amount of co-insurance and deductible balances applicable to GCHS claims that exceed $2,500 for a policy year.

An application form is enclosed. Please complete all information. An incomplete application will delay any decision.

Family income and size are used to determine eligibility.

- The number of dependents listed on your most recent federal income tax return determines the family size.
- Income is based on your family income.
- Income information is verified by your current income tax return and/or review of the prior three months pay stubs. If you have changed jobs, or became unemployed recently, note that on the application.

Assistance is available on a sliding scale as shown on the back of the application.

Use the checklist below to ensure that your application is complete.

_____ Complete and sign application

_____ Enclose copy of tax return

_____ Provide copy of Medical Assistance approval or denial

_____ Enclose proof of income for last 30 days
(i.e. pay stubs, social security, disability, unemployment statements)

_____ For co-insurance and deductible balances provide a copy of EOBs for the current policy year showing the balances exceed $2,500

If you have questions regarding this application, contact the business office at 724-450-7020.

Mail completed application and supporting documents to:

Business Office
Grove City Medical Center
631 North Broad Street Ext.
Grove City, PA 16127

**Does not include services provided by Brighton Radiology*
Includes services provided by Grove City Medical Center Pathology, Grove City Medical Center Cardiology, Grove City Anesthesia and Pain Management and UPMC Emergency Medicine Inc.

GROVE CITY HEALTH SYSTEM
APPLICATION FOR FINANCIAL ASSISTANCE
FOR SERVICES RENDERED BY (Check applicable locations)
____GROVE CITY MEDICAL CENTER ____WOLF CREEK MEDICAL ASSOCIATES

Applicant/Financially Responsible Person Name (First and Last): _____ Date of Birth: ___/___/___
Street Address: _____ City/State/Zip: _____
Home Telephone: (___) _____ Work Telephone: (___) _____

Patient Name (First and Last): _____ Date of Birth: ___/___/___ Social Security #: _____
Street Address: _____ City/State/Zip: _____
Home Telephone: (___) _____ Work Telephone: (___) _____
Current Health Insurance Company: _____ Policy Number: _____ Group Number: _____

If you are uninsured, you may qualify for Medical Assistance. Have you applied for Medical Assistance in the past six months? Yes / No

FAMILY MONTHLY INCOME

Wages/Self Employment	$_____
Social Security/Pensions	$_____
Disability/SSI	$_____
Unemployment Compensation	$_____
Workers Compensation	$_____
Child/Spousal Support	$_____
Public Assistance	$_____
Annuities	$_____
Trusts, Interest/Dividends	$_____
Other	$_____
Total Monthly Income	$_____

FAMILY MONTHLY EXPENSES

Mortgage/Rent	$_____
Property Taxes	$_____
Insurance	$_____
Automobile	$_____
Credit Cards (Total)	$_____
Water/Gas/Oil/Electric	$_____
Medical	$_____
Child/Spousal Support	$_____
Health Savings Account	$_____
Telephone/Other	$_____
Total Monthly Expenses	$_____

ALL FAMILY MEMBERS

	Name	Relationship/Age
1	_____	Self/_____
2	_____	Spouse/_____
3	_____	_____
4	_____	_____
5	_____	_____
6	_____	_____
7	_____	_____
8	_____	_____

FAMILY COUNTABLE RESOURCES (LIQUID ASSESTS)

Checking Account Balance	$_____
Savings Account Balance	$_____
Certificates of Deposits	$_____
Savings Certificates/U.S. Savings Bonds	$_____
Stocks/Bonds	$_____
Trust Fund	$_____
Health Savings Accounts (HSA) Funds	$_____
Other (Please explain)	$_____

I certify that the information contained in this application is true and complete. I understand that willful falsification of information contained in this application will result in denial of financial assistance. I am aware that the information provided on this application is subject to verification by Grove City Health System.

_____ _____
Applicant Signature Date

OUTSTANDING BALANCES

Account #	Date of Service	GCMC	WCMA	Professional Fees

Are the accounts reimbursable by an employer Health Reimbursement Arrangement (HRA)? Yes / No

Grove City Health System Use Only:

Authorized by: _____ **Date:** _____ **Denied** _____ **Approved at** _____%

Reason Denied: _____ **Date Notification Sent:** _____

FINANCIAL ASSISTANCE PROGRAM
INCOME GUIDELINES
2018

Table I. Federal Poverty Guidelines

Family Size	Yearly Income
1	12,140
2	16,460
3	20,780
4	25,100
5	29,420
6	33,740
7	38,060
8	42,380
For each add'l person, add	4,320

Table II. Income limits for financial assistance

	100 % Discount	91 % Discount	82% Discount	73% Discount	65% Discount
Family Size	200% Poverty Level	>200%to 225% Poverty Level	>225% to 250% Poverty Level	>250% to 275% Poverty Level	>275% to 300% Poverty Level
1	24,280	24,281-27,315	27,316-30,350	30,351-33,385	33,386-36,420
2	32,920	32,921-37,035	37,036-41,150	41,151-45,265	45,266-49,380
3	41,560	41,561-46,755	46,756-51,950	51,951-57,145	57,146-62,340
4	50,200	50,201-56,475	56,476-62,750	62,751-69,025	69,026-75,300
5	58,840	58,841-66,195	66,196-73,550	73,551-80,905	80,906-88,260
6	67,480	67,481-75,915	75,916-84,350	84,351-92,785	92,786-101,220
7	76,120	76,121-85,635	85,636-95,150	95,151-104,665	104,666-114,180
8	84,760	84,761-95,355	95,356-105,950	105,951-116,545	116,546-127,140
For each add'l person, add the following amount to the upper limit	8,640	9,720	10,800	11,880	12,960

Family income greater than 300% of the federal poverty guidelines is not eligible for financial assistance but will receive a 40% self-pay discount.