

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 ASSETS)

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
2017**

Table I. Federal Poverty Guidelines

Family Size	Yearly Income
1	\$12,060
2	\$16,240
3	\$20,420
4	\$24,600
5	\$28,780
6	\$32,960
7	\$37,140
8	\$41,320
For each add'l person, add	\$4,180

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	24,120	24,121-27,135	27,136-30,150	30,151-33,165	33,166-36,180
2	32,480	32,481-36,540	36,541-40,600	40,601-44,660	44,661-48,720
3	40,840	40,841-45,945	45,946-51,050	51,051-56,155	56,156-61,260
4	49,200	49,201-55,350	55,351-61,500	61,501-67,650	67,651-73,800
5	57,560	57,561-64,755	64,756-71,950	71,951-79,145	79,146-86,340
6	65,920	65,921-74,160	74,161-82,400	82,401-90,640	90,641-98,880
7	74,280	74,281-83,565	83,566-92,850	92,851-102,135	102,136-111,420
8	82,640	82,641-92,970	92,971-103,300	103,301-113,630	113,631-123,960
For each add'l person, add the following amount to the upper limit	8,360	9,405	10,450	11,495	12,540

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