



APPLICATION FOR FINANCIAL ASSISTANCE

Section One: Required Questions

Please complete all questions in this section. Failure to complete this section could result in delays in evaluating eligibility for charity care.

Patient Information

Patient Name: _____ Date of Birth: _____
Street Address: _____ Home Telephone: _____
City/State/Zip: _____ Work Telephone: _____

Current Health Insurance Company Name: _____
Policy Number _____ Group Name/Number: _____

Household Members

Please attach additional sheets of paper if household has more than eight members.

Table with 3 columns: Name, Relationship, Age. Rows 1-8 for household members.

Monthly Household Income

Wages/Salaries (Before Taxes): _____ Worker's Compensation: _____
Pensions: _____ Child Support: _____
Social Security: _____ Spousal Support: _____
Other Disability: _____ Veteran's Admin (VA) Benefits: _____
SSI: _____ Annuities: _____
Cash Assistance: _____ Other Unearned Income (includes Trusts, Interest/Dividends, etc): _____
Unemployment Compensation: _____

Household Countable Resources

Please list your available accounts and liquid assets for your household. A liquid asset is defined as cash or any type of negotiable asset that can be converted quickly and easily into cash. Do not include your home, household items, vehicles, IRAs, 401(k) accounts and other non-liquid assets.

Certificates Deposit: _____ Christmas or Vacation Club: _____
Stocks or bonds: _____ Savings Certificates: _____
Trust Fund: _____ Health Savings Account (HSA) funds: _____
Savings account: _____ U.S. Savings Bonds: _____
Checking Account: _____ Other (Please Explain): _____



APPLICATION FOR FINANCIAL ASSISTANCE

Section Two: Optional Questions

If you so choose, please answer the questions below to provide a better understanding of your ability to pay for medical care. Higher-than-average or otherwise unusual expenses may result in an adjustment of income downward. Lower-than-average expenses will not result in an adjustment of income upward.

Monthly Household Expenses

Mortgage/Rent: _____ Oil: : _____
Property Taxes: _____ Electric: : _____
Insurance: _____ Telephone: _____
Auto Loan: _____ Child Support: _____
Credit Cards (Total) : _____ Spousal Support: _____
Water: _____ Health Savings Account (HSA) Contributions: _____
Gas: _____ Other (Please Explain) : _____

Monthly Medical Expenses

Insurance Premiums: _____ Doctors' Visits: _____
Equipment: _____ Prescriptions: _____
Hospital: _____

Section Three: Verification of Income and Countable resources

Please verify all income and resources listed in Section One. If you are unable to verify some or all of your income or resources, please explain why on an attached sheet of paper. Applications will not be rejected for inability to verify income or resources, provided that reasonable explanation for the inability is given. Acceptable sources of verification include, but are not limited to:

- Copy of most recent Federal income tax return.
Award letters or bank statements showing deposits of Social Security, other disability, pension, worker's compensation, or unemployment compensation payments.
Award letters, court documents, or bank statements showing deposits of child or spousal support payments.
Documentation of other sources of income.
If the household has no income, letters from persons who are assisting with daily living needs, explaining the help that the persons provide (e.g., grocery purchases or rent and utility payments).
Health Savings Account (HAS) and other dedicated account statements.
Checking and Savings account statements.
Copy of Health Insurance Card(s), if applicable

Section Four: Certification

Please sign and return the completed application with the items listed in Section Three to

Holy Redeemer Health System
Central Business Office
Attn: Customer Service
12265 Townsend Road
Philadelphia, PA 19154

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.

Signed: _____ Dated: _____