Before applying for Charity Care you must first apply for Medical Assistance/Medicaid and be denied as over income or over resources.

The Medicaid denial must be submitted with your Charity Care Application. If you need assistance with applying for Medical Assistance/Medicaid please contact your County Assistance Office or one of our Patient Counselors.

It may be possible to receive help with your bill(s). We need several things from you to consider your request:

- Complete the financial aid application. **Both pages.**
- **Sign and date** the application.
- Proof of monthly household income:
  - ✓ Current and complete bank statement for checking , savings, business accounts showing all transactions for last 30 days
  - ✓ Current pay stubs for the last 30 days
- Copy of last filed federal tax return with all schedules
- If you do not file then we need a letter stating the reason why you do not file and the letter must be signed & dated
- **Current denial or approval from Medical Assistance/Medicaid**

Proof of income is important. You must send it with the application. Applications without income information are denied. The person who helps you with daily living expenses must write a letter if you have no household income.

You must send us copies if you get any of these benefits:

- Notice received from Social Security Administration indicating monthly benefit
- Any pension payments that are received monthly
- Notice received from Bureau of Unemployment for weekly benefit

Your aid may be reduced or denied if you refuse to enroll in a subsidized health plan. That is because of individual insurance mandates from the Affordable Care Act and expanded Medicaid in Pennsylvania.

Call us if you have questions at (814)643-8844 or (814)643-8495

Sincerely,

Financial Aid Representative

Attachment A

RETURN TO: Patient Financial Aid Counselors
J.C. Blair Memorial Hospital
1225 Warm Springs Avenue
Huntingdon, PA 16652

FINANCIAL AID APPLICATION

Patient Name: ______________________________

Last First MI

Patient Address: ______________________________

Address

____

City **Patient's Phone Number**

____

State Zip Code **Patient's Birthdate**

Guarantor's Information (If Different Than Patient)

Name ______________________________

Last First MI

Social Security # ______________ Birth date ______________

Relationship ______________ Phone ______________

Household Members:

Name	Relationship	Age	Sex

Household Income

Employer/Occupation

	Monthly Gross Amount	Tax Deductions
Wages: Self ______________		
Spouse ______________		
Others ______________		
Self-Employment		
Pensions		
Social Security/SSI		
Unemployment or Workers Compensation		
Child/Spousal Support		
401 K Plans/ Other Annuity Payments		
Veteran's Administration (VA) Benefits		
Public Assistance		
Income from Dividends, Interest, Rent		
TOTAL INCOME		

Expenses

	Creditor Name	Monthly Payment	Account Balance
Mortgage/Rent			
Auto Loans/Leases			
Credit Cards			
Bank Loans			
Taxes Personal			
Real Estate			
Medical Bills			
Prescription Medicines			
Spousal Support			
Child Care/Support			
Phone (inc cell)/Cable/Internet			
Electric			
Water			
Gas/Oil			
Sanitation			
Insurance car			
individual			
home			
health			
TOTAL EXPENSES			

Assets (PROVIDE COPY OF FINANCIAL INSTITUTION STATEMENTS)

	Bank Name	Balance of Account ($)
Checking Account		
Savings Account		
Christmas/Vac.Club		
Certificate of Deposit		
Money Market Acct.		
Stocks/Bonds		
Health Savings Acct.		
Trust Fund/Annuities		
Other Assets		

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 charity care.

Signature of Patient Or Guarantor ______________________ Date: ______________________ Spouse: ______________________ Date: ______________________