Penn Medicine

FINANCIAL ASSISTANCE APPLICATION

Please mail completed application form and copies of your proof of income materials to:

Penn Medicine
Attn: Financial Assistance
P.O. Box 824406
Philadelphia, Pa 19182-4406

If you have any questions, assistance is available.

Please call toll-free. 1-800-406-1177 or go to https://www.pennmedicine.org/for-patients-andvisitors/penn-medicine-locations to find a UPHS location that can assist you.

Additional info1mation is also available on the web at: https://www.pennmedicine.org/for-patients-and-visitors/patient-information/insurance-and-billing/billingand-financial-assistance

Documentation Checklist

Your application must include copies of the following documents that apply to you. Please attach copies, not originals, as Penn Medicine cannot return any documents that are sent in with the application. If any of the documents are missing, it will delay processing of your application.

If you have income

Attach additional proof of your household income, which may include some of the following:

- ☐ Pay stubs for previous 30 days
- ☐ If you are self-employed, you must include a copy of your Schedule C and/ or profit and loss statement.
- ☐ Social Security 1099 forms or award letters.
- ☐ Pension or retirement income statements.
- ☐ Dividends and interest income statements.
- ☐ Rent or royalty income statements.
- ☐ Unemployment or workers' compensation award letters.
- ☐ Proof of alimony and/or child support.
- ☐ Other income.

If You Have No Income

- ☐ If you have no income, send us a letter of support. The person who provides your support must sign the letter.

Letter of Denial of Medical Assistance

- ☐ You need to apply for Medical Assistance and send a copy of your Letter of Denial before we can approve your application

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(This application applies to all Entities included in the Financial Assistance Policy provider list)

Name of Patient: _____

Patient's Date of Birth: _____

Address: _____
Number and Street *City* *State* *ZIP* *Country*

Daytime Phone Number: _____ Alternate Phone Number: _____

Employer's Name: _____ Spouse's Employer: _____

REQUESTED SERVICES: Check the services for which you are requesting financial assistance.
These services were provided by (check all that apply):

☐ Penn Medicine Hospitals ☐ Penn Medicine Physician Services ☐ Penn Medicine Home Care Services

If you have already received a bill, please provide the following:

Account Number: _____ Balance Due: _____

HOUSEHOLD INFORMATION: List ALL members of your household who were claimed on your most recent IRS Form 1040 (additional names can be provided on a separate list if necessary)

Names	*Relation to Patient*	*Age*

Total Number of Household Members (including the patient): _____

Penn Medicine

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MONTHLY HOUSEHOLD INCOME: **Give monthly income for yourself and other household members. Please attach a proof of income documents (see documentation checklist).**

*Self*_____ *Spouse and/or other household members*_____

Wages/Self-employment

$_____ $_____

Social Security

$_____ $_____

Pension or retirement income

$_____ $_____

Dividends and interest

$_____ $_____

Rents and royalties

$_____ $_____

Unemployment

$_____ $_____

Workers' Compensation

$_____ $_____

Alimony and Child Support

$_____ $_____

Other Income

$_____ $_____

Total Monthly Family Income

$_____ $_____

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MONTHLY HOUSEHOLD EXPENSES: Give information about the bills you pay every month.

Mortgage/Rent: $_____ Utilities: $_____ Real Estate Tax: $_____

Food: $ _____ other, please describe: $_____

Additional Comments:

_____

_____

_____

_____

Disclaimer: I understand that the information I provide will be used only to determine financial responsibility for my charges at Penn Medicine (hospital, physician or home care) and will be kept confidential. I understand that the materials I send to prove my income and assets will not be returned. I further understand that the information which I submit concerning my annual family income and family size is subject to verification by Penn Medicine. I understand that if any information I have given is determined to be false, it may result in reversing the financial assistance approval and I will be liable for the full amount of all my charges.

My signature authorizes Penn Medicine to verify all information provided on this form. I certify that the above information is true and accurate to the best of my knowledge.

Signature: _____

Relationship to Patient: _____

Date: _____