EVANGELICAL
COMMUNITY HOSPITAL
Excellence Every Day.

Date:

Medical Record Number:

Dear _____ :

Please complete the attached EVANGELICAL COMMUNITY HOSPITAL Financial Assistance Program application and return it within **15 days** using the self-addressed envelope provided for your convenience. Medical Assistance requires that you apply for eligibility within 90 days from your most recent date of service (special cases may be exempt from applying for Medical Assistance). A Medical Assistance notice of approval or denial will be sent to you. **Please include your Medical Assistance denial with this application**. It is very important that this application be filled out completely. We at EVANGELICAL COMMUNITY HOSPITAL are committed to the care and improvement of human life. We are also committed to providing quality care that is sensitive, compassionate, promptly delivered and cost effective. Our facility provides EVANGELICAL COMMUNITY HOSPITAL Financial Assistance Program to individuals who meet the Federal Poverty guidelines and is compliant with their rules and regulations.

To enable us to make a determination, please furnish us with the following documents to prove income:

1. Documentation of the gross monthly income for you and for all members of your household.
2. Medical Assistance notice of denial. Please call the Financial Counselors so they can screen for Medical Assistance. If you do meet the criteria they will set-up an appointment for you to come in and fill out the application. If you do **NOT** meet the criteria they will fill out the notice of denial.
3. Copies of your entire income tax return(s) from the last calendar year.
4. If currently employed copies of pay stubs for the last 3 months.
5. Copies of Social Security Eligibility Income statement(s), where applicable.
6. Please attach an additional page should the financial worksheet not have enough space for your information. Upon receipt of this information, we will review all information provided to make a determination compliant with Federal regulations.

Your application cannot be considered if it is not signed and dated or if any of the requested documentation is not received.

The application must be returned with **15 days** from the date of this letter. Failure to submit documentation may result in denial of your request. Please return by: _____

EVANGELICAL COMMUNITY HOSPITAL will make available a reasonable amount of Financial Assistance Services to persons eligible under applicable Federal Community Services Administration Guidelines. Patient eligibility for EVANGELICAL COMMUNITY HOSPITAL Financial Assistance Program is determined by measuring family income against the Income Poverty Guidelines established by the Federal Community Services Administration. The current requirements are:

2024 Health and Human Services Poverty Income Guidelines for the 48 Contiguous States and the District of Columbia

FREE CARE (100%FPL)		85% Discount (125%FPL)		70% Discount (150% FPL)		55% Discount (200% FPL)	
SIZE OF HOUSEHOLD	2024 POVERTY GUIDELINES	GREATER THAN	UP TO	GREATER THAN	UP TO	GREATER THAN	UP TO
1	$ 15,060	$ 15,060	$ 18,825	$ 18,825	$ 22,590	$ 22,590	$ 30,120
2	$ 20,440	$ 20,440	$ 25,550	$ 25,550	$ 30,660	$ 30,660	$ 40,880
3	$ 25,820	$ 25,820	$ 32,275	$ 32,275	$ 38,730	$ 38,730	$ 51,640
4	$ 31,200	$ 31,200	$ 39,000	$ 39,000	$ 46,800	$ 46,800	$ 62,400
5	$ 36,580	$ 36,580	$ 45,725	$ 45,725	$ 54,870	$ 54,870	$ 73,160
6	$ 41,960	$ 41,960	$ 52,450	$ 52,450	$ 62,940	$ 62,940	$ 83,920
7	$ 47,340	$ 47,340	$ 59,175	$ 59,175	$ 71,010	$ 71,010	$ 94,680
8	$ 52,720	$ 52,720	$ 65,900	$ 65,900	$ 79,080	$ 79,080	$ 105,440
ADD $5380 FOR EACH ADDITIONAL MEMBER OF THE HOUSEHOLD							

If you have any questions or need assistance, please feel free to contact our **Financial Counselors at (570)-522-4445.**

APPLICATION FOR EVANGELICAL COMMUNITY HOSPITAL/EVANGELICAL MEDICAL SERIVCES ORGANIZATION FINANCIAL ASSISTANCE PROGRAM

Date of Application _____

Applicant Name _____

SS# _____ DOB _____ Phone_____

Address _____

Address _____

City _____ST_____ZIP _____

Members of Household

_____SS# _____ DOB _____

_____SS# _____ DOB _____

_____SS# _____ DOB _____

_____SS# _____ DOB _____

_____SS# _____ DOB _____

_____SS# _____ DOB _____

	Account#	**Amount**
Patient Account(s) #/Amount	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

INCOME (Include all household members)

	Total last 3 Months	Total Last 12 Months
Gross Wages	_____	_____
Social Security Benefits	_____	_____
Pension Income	_____	_____
Public Assistance	_____	_____
Dividend & Interest	_____	_____
Rental Income	_____	_____
Farm or Self Employment Income	_____	_____
Unemployment Compensation	_____	_____
Worker's Compensation	_____	_____
Strike Benefits	_____	_____
VA Benefits	_____	_____
Military Family Allotments	_____	_____
Alimony	_____	_____
Child Support	_____	_____
Other Income	_____	_____
TOTAL INCOME (before taxes)	_____	_____

Please provide copies of your most recent 1040 and W-2 and/or three months of current pay stubs, and medical assistance notice of denial or eligibility (Medical Assistance denial notice must be dated within 6 months of this application). Additional information on assets may be requested.

EMPLOYER INFORMATION

Head of Household Employer Name _____

Employer Address _____

Additional Employer Names _____

Employer Address _____

I certify that the above information is true and correct to the best of my knowledge and further agree that falsification herein will disqualify me or my dependent(s) for charitable services. I understand the information submitted is subject to verification.

_____ _____

Patient Signature Date

_____ _____

Responsible Party Signature Date