BUCKTAIL MEDICAL CENTER

APPLICATION FOR FINANCIAL ASSISTANCE

See attached instructions for completing this application. If you need help completing this application, please call 570-923-1000 or stop by the Main Registration Desk or Business Office

Need health insurance? *Visit: Healthcare.gov or call 1-800-318-2596 to learn more.*

SECTION 1

NAME: LAST | FIRST | MI | DATE OF BIRTH

ADDRESS: STREET | CITY/STATE | ZIP CODE

OTHER: SOCIAL SECURITY # | HOME PHONE | OTHER PHONE

SECTION 2

Are you currently employed? **Y N** If Yes, name of employer: _____

If not employed, what is your source of income? _____

SECTION 3

Is person applying same as patient? **Y N** If No, Patient Name: _____

FAMILY SIZE:

(list all household members:)	**Name**	**AGE/Date of Birth**	**Relationship**
1. Self			Self
2. **SPOUSE/PARTNER**			
3. **OTHER HOUSEHOLD MEMBER(S)**			
4. **OTHER HOUSEHOLD MEMBER(S)**			
5. **OTHER HOUSEHOLD MEMBER(S)**			
6. **OTHER HOUSEHOLD MEMBER(S)**			

Total household/family Size: _____

Are you or any family members covered by Medicaid/Assistance or another insurance? Yes No

If Yes, who & group Name/group #: _____

SECTION 4

If your account balance is $500 or more, you will be required to apply for Pennsylvania Medicaid

NOTE: Page 2 - Income/Asset Information is REQUIRED for your application to be considered

CERTIFICATION (MUST BE SIGNED AND DATED):

I certify that the above information is true and accurate to be best of my knowledge. Further, I will make applications for assistance (Medical Assistance, Medicare, Insurance, etc.) which may be available for payment of my charges and I will take any action necessary to obtain such assistance and will assign or pay Bucktail Medical Center the amount recovered for my service. If any information I have given proves to be untrue, I understand Bucktail Medical Center may reevaluate my financial status and deny my application for Charity Care/Financial Assistance.

_____ _____

Applicant Signature **Date**

SECTION 5

FOR BMC USE ONLY: Tracking ID#: _____

Date application received: _____ Page 2 completed? Y N

DETERMINATION INFORMATION:	Determination Date	N/A	Notification Date	Resources Used/Notes:
Presumptive Eligibility:				
Eligible/Approved:				
Ineligible:				

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SECTION 6

Is your bill $500 or more? If it is and you have not applied for PA Medicaid, then you must apply and BMC must receive a copy of your determination. Either call 570-748-2971 or apply online at: http://www.compass.state.pa.us **Date applied?** _____

If you need assistance with your application, please contact the BMC Billing Office at 570-531-6154.

INCOME INFORMATION:

Do you file income taxes?	**Y N** If Yes, attach the following:	**Is Proof Attached?**
	- Most recently filed FEDERAL Income Tax Return (must be signed)	
	- All W-2's; 1099's & other 'Schedule" forms used to file	

SECTION 7

What is your Household Income (use before tax/Gross Income) for the last 30 days?

In this section, provide all income sources for everyone in your household. This can include, but is not limited to: Employment; Public Assistance/Welfare; Social Security; SSI; Disability; Worker's Comp; Unemployment; Pension/Retirement; Interest/Dividends; self employment; child support; rental income; refunds (rent/tax); etc.

You will be required to provide proof for each income source. This can be done by providing copies of a full month's worth of income as can be seen on pay stubs; bank statements; annual Social Security statements; etc.

Household Member Name:	Please Describe the Source/Type of Income:	Estimated Monthly Amount:	**Is Proof Attached?**
		$	
		$	
		$	
		$	
		$	

Applications will not be rejected for inability to verify income/resources, provided that reasonable explanation for inability is given.

Other available resources - please provide proof for the last 30 days or most recent statement(s):

Do you rent/lease or own your home? Address: _____
If rent, monthly Amount: $ _____
If own, monthly mortgage, if any: $ _____

Do you have a checking account? If yes - current balance $ _____
Bank name/location: _____

Do you have a savings account? If yes - current balance $ _____
Bank name/location: _____

Do you have CD's; stock/mutual funds/bonds? If yes - current balance $ _____
Name of accounts/what company(s)? _____

Do you have other accounts? (examples: Christmas Club; PayPal) If yes - current balance $ _____
Name of accounts/what company(s)? _____

SECTION 8

Expenses (If you choose, please answer the questions below to provide a better understanding of your ability to pay for care):

What are your estimated monthly household expenses?		What are your estimated monthly medical expenses?	
Water/Sewerage	$	Health Insurance Premium	$
Fuel - Heat/Electric	$	Prescription(s)	$
Auto Loans	$	Medical Bill(s)	$
Auto Insurance	$	Dental Bill(s)	$
Property Taxes(s)	$	Medical Equipment Bill(s)	$
Home Insurance	$	Doctor Visits	$
Credit Card(s)	$	Other _____	$
Loan/Lease(s)	$	Other _____	$
Other _____	$		

If you have any questions about this application and the required information, please call

570-923-1000 or stop by Main Registration or Business Office at 1001 Pine Street, Renovo

Form version: 19-001 rev. 4/1/2019