Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE.

Lehigh Valley Health Network
Financial Assistance Program Application

Lehigh Valley Health Network (LVHN) offers financial assistance for medically necessary care provided to eligible individuals and families. Your financial need will determine a reduction or elimination of your financial obligation.

You may qualify for LVHN's Financial Assistance Program (FAP) if you:

- Have limited or no health insurance
- Are not eligible for government assistance such as Medicaid
- Cooperate in providing necessary information to support your financial needs
- Reside in the following counties: Lehigh, Northampton, Bucks, Montgomery, Berks, Schuylkill, Carbon or Monroe

The process to apply for Financial Assistance is as follows:

- Complete the LVHN Financial Assistance Program Application
- Include documentation listed on checklist
- In order to determine eligibility, LVHN will need proof of your income and household size (We use the Federal Poverty Guidelines to determine financial need)
- You will need to help LVHN determine if there are payment options through insurance such as Workers Compensation, Auto, Liability, or Medicaid etc…
- If needed, LVHN will assist in setting up a payment plan for any balance for which you are financially responsible
- This program will be applied only to eligible services provided by Lehigh Valley Health Network
- After you complete the application, LVHN will notify you by mail to inform you if you qualify for the Financial Assistance Program

You may be required to complete a Medical Assistance application at any time during the process.

Failure to cooperate in the Medical Assistance application process will terminate your FAP eligibility.

If you have any questions regarding this application please contact:

LVHN Financial Counselor office message line at 484-884-0840
Monday through Friday 8:00 AM to 4:00 PM EST

For more information about our Network, please visit us at: www.lvhn.org

Financial Assistance Program Application Checklist

1. **If you have income:**

   ☐ Attach a copy of your most recent Federal Income Tax Return
   (1040, 1040A, 1040EZ   If you filed taxes, you must supply a copy of the return)

2. **If you did not file a federal tax return, you must:**

   ☐ State in writing why you did not file a Federal Income Tax Return on a separate sheet of paper
   ☐ Send us a copy of the most recent federal income tax return of anyone who claimed you as a dependent

3. **Attach additional proof of household income, if applicable:**

   ☐ 1099 forms or award letters: Social Security, Pension/Retirement, Disability, etc…
   ☐ Unemployment Notice of Final Determination or Workers Compensation
   ☐ Pay stubs for the last three months
   ☐ If you are self employed, you must include a Schedule C and/or statement of income and expenses

4. **If you have no income:**

   ☐ A notarized letter of no income will be required
   (An LVHN Notary can notarize a letter stating the patient or financially responsible individual has no income)

5. **Letter of Denial for Medical Assistance:**

   ☐ Based on initial financial screening, you may need to apply for Medical Assistance and provide a copy of your Letter of Denial before LVHN can approve your application

6. **Completed and signed Financial Assistance Program application:**

   ☐ Make sure to complete and include **<u>all information</u>** that applies to you

Financial Assistance Is Not Health Insurance

FINANCIAL ASSISTANCE PROGRAM APPLICATION

PATIENT INFORMATION (Please Print)

Name of Patient:		
Patient's Date of Birth:	Patient's Social Security Number:	
Address: Number and Street/City/State/Zip		County(**Must Complete**)
Daytime Phone Number:	Alternate Phone Number:	
Employer Name:	Spouse's Name: Spouse's Employer Name: Spouse's Social Security Number:	

If you have already received a bill, please give us your account number(s):

Dependents (including the patient): Dependents as reported on your Federal Tax Return	
- they live with you for more than half of the year - do not provide more than half of their own support for the year - permanently disabled	- are under the age of 19 - are under 24 and a student

Number of Dependents - Include yourself if you are the patient					
Name	Relation to Patient	Age	Name	Relation to Patient	Age

Medical Resources: Health Savings Account/ Flexible Spending Account/Medical Savings Account
Account Name:
Account Number:

Health Insurance Information: (If Applicable- List All) *Use extra paper if needed and include card copies*	
Name of Company:	Subscriber Name:
ID Number:	Group Number:
Insurance Claims Address:	
Insurance Phone Number:	

Have you applied for Medical Assistance in the past 6 months? ___Yes ___No

If YES, please enclose a copy of the Letter of Denial or Proof of Eligibility (include letter or Access card).

If NO, please contact your local county assistance office for guidance on how to apply for these benefits.

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Financial Assistance Program Application (Page 2)

Did LVHN provide care for injuries suffered in an accident caused by someone else? ___Yes ____No

If yes, describe below the circumstances of that accident. If you intend to make a claim against the person responsible for causing your injuries, please identify any attorney you have retained to represent you in connection with that claim.

Date of Accident: ____
Nature of Accident: ____
Responsible Party: ____
Name and phone number of Attorney: ____

Monthly Household Income: Give monthly income for yourself and other household members. Also attach copies of your Federal Tax Return and other proof of income documents (see documentation checklist).					
	Self	Spouse and/or other household members		Self	Spouse and/or other household members
Wages/Self-Employment			Unemployment		
Social Security			Workers Compensation		
Pension or Retirement Income			Alimony and Child Support		
Dividends and Interest			Other Income		
Rents and Royalties			Total Monthly Family Income		

I certify that the above information is true and complete to the best of my knowledge.
I agree to apply for any assistance (Medicaid, Medicare, insurance) which may be available for payment of my LVHN account, and I will take any action reasonably necessary to obtain such assistance.

I understand that this application is made so that LVHN can determine my eligibility for Financial Assistance. If any information I have given proves to be false, I understand that LVHN will re-evaluate my financial status and qualification for Financial Assistance.

I authorize any bank, loan institution, insurance company, employer, or any creditor whatsoever of the undersigned to release any information requested by LVHN pertaining to any and all financial matters involving or relating to the undersigned.

I understand if I am approved for Financial Assistance or charity care and make a claim to recover damages from the third party causing the injuries, for which I received care at LVHN, I am required to notify LVHN Patient Financial Service of that claim. I further understand that under those circumstances my financial assistance or charity care approval will be reclassified and placed in a pended status until the claim is resolved and it is determined how much of my recovery should be paid to LVHN.

Signature:_____________________________________Date:______________________________

Relationship to Patient: ____

Approved By:__________________________________Date:_______________________________
(Lehigh Valley Health Network Representative)

Please detach this form and forward it to:

Lehigh Valley Health Network
ATTN: Patient Financial Services, Financial Counselor
2100 Mack Blvd
PO BOX 4120
Allentown PA 18105-4120