Lehigh Valley Health Network

# *Financial Assistance Is Not Health Insurance*
# FINANCIAL ASSISTANCE PROGRAM APPLICATION

## PATIENT INFORMATION (Please Print)

| | | |
|---|---|---|
| Name of Patient: | Medical Record Number: | |
| 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:<br>Spouse's Employer Name:<br>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 | Date of Birth | Name | Relation to Patient | Date of Birth |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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

| Health Insurance Information: (**Must Complete**) *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.

**(See Other Side, Page 2)** **A**

**Financial Assistance Program Application (Page 2)**

# *Financial Assistance Is Not Health Insurance*

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, or if you have already recovered any amount on account of such a claim, 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 | | Self | Spouse |
|---|---|---|---|---|---|
| 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 | | |
| | | | Adjusted Gross 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 and make a claim to recover damages from the third party causing the injuries, for which I received care at LVHN, or my own un/underinsurance, I am required to notify LVHN Patient Financial Services of that claim. I further understand that under those circumstances my Financial Assistance 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:_____ (Must be Power of Attorney or Parent or Legal Guardian of Minor Child- must show proof)

Do you give us permission to speak to someone else regarding your FAP application and related information? ☐ Yes ☐ No

If yes, who can we speak to?_____

**Please detach this form and upload to MyLVHN, Fax 484-884-8527 or forward it to:**

**Lehigh Valley Health Network**
ATTN: Patient Access, Financial Counselor
2100 Mack Blvd, 3rd Floor
PO BOX 1866
Allentown PA 18105-1866

2/26/2024-LT