CORRY MEMORIAL HOSPITAL

Attention: Patient Financial Services
965 Shamrock Lane, CORRY, PA 16407-9121
(814) 664-4641

CMH COMMUNITY CARE PROGRAM FAP Application

PLEASE ***COMPLETE THE INFORMATION BELOW WITHIN 15 DAYS OF RECEIPT.***
RETURN THIS FORM AND SUPPORTING DOCUMENTATION TO THE **ADDRESS ABOVE.**
This information is required to qualify your account(s) for our Patient Financial Program (CMH Community Care).
THANK YOU FOR YOUR COOPERATION

PATIENT NAME _____ GUARANTOR STMT # _____

PATIENT SS# _____ DATE OF BIRTH: _____

Street Address: _____

City/State/Zip: _____

Home Telephone: _____ Work Telephone _____

Current Health Insurance Company Name: _____

Policy Number: _____ Group Name/Number: _____

HOUSEHOLD MEMBERS: (Please attach additional sheets of paper if household has more than eight members.)

	NAME:	RELATIONSHIP:	AGE:
1.	_____	Self _____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

MONTHLY HOUSEHOLD INCOME:

Wages/Salaries (Before Taxes): _____

Pensions: _____

Social Security: _____

Other Disability: _____

SSI: _____

Unemployment Compensation: _____

Worker's Compensation: _____

Child Support: _____

Spousal Support: _____

Veteran's Administration (VA) Benefits: _____

Annuities: _____

Other Unearned Income (includes Trusts, Interest/Dividends, etc): _____

HOUSEHOLD COUNTABLE RESOURCES:

Please list your available bank accounts and liquid assets for your household. A liquid asset is defined as cash or any type of negotiable asset that can be converted quickly and easily into cash. **Do not include your home, household items, vehicles, IRAs, 401(k) accounts and other non-liquid assets.**

Certificates of Deposit: _____ Stocks or Bonds: _____

Trust Fund: _____ Savings Account _____

Checking Account: _____ Savings Certificates: _____

U.S. Savings Bonds: _____ Christmas or Vacation Club: _____

Health Savings Accounts (HAS) funds: _____

Other (Please explain): _____

MONTHLY HOUSEHOLD AND MEDICAL EXPENSES:

Mortgage/Rent: _____ Property Taxes: _____

Insurance: _____ Auto Loan: _____

Credit Cards (total): _____ Water: _____

Gas: _____ Oil: _____

Electric: _____ Telephone: _____

Child Support: _____ Spousal Support: _____

Health Savings Account (HAS) Contributions: _____

Insurance Premiums: _____ Equipment: _____

Doctors' Visits: _____ Prescriptions: _____

Other (please explain): _____

VERIFICATION OF INCOME AND COUNTABLE RESOURCES:

Please attach proof of income for the **past 30 days** and current resources to this application. If you are unable to provide verification of your incomes or resources, please explain why on an additional sheet of paper and attach it to your application. Acceptable sources of verification include, but are not limited to:

- Pay stubs or letters from employers, listing wages before taxes.
- Income Tax Returns
- Award letters or bank statements showing deposits of Social Security, other disability, pension, worker's compensation, or unemployment compensation payments.
- Award letter, court documents, or bank statements showing deposits of child or spousal support payments.
- Documentation of other sources of income.
- If the household has no income, letters from persons who are assisting with daily living needs, explaining the help that the persons provide such as groceries, rent or utility payments.
- Health Savings Account (HAS) and other dedicated account statements.
- Checking and Savings account statements.
- Copy of Health Insurance Card(s), if applicable.

I certify that this application is true and accurate to the best of my knowledge. Furthermore, I agree to go through the hospital's screening process for insurance (Medicaid, Medicare, or other insurances as identified) which may be available for payment of my hospital charges. I will take any action reasonably necessary to obtain such insurance. Additionally, any amounts recovered for hospital charges will be assigned or paid to the hospital. If any information I have given proves to be untrue, I understand that I may no longer be eligible for uncompensated services and will be responsible for any uncovered charges.

SIGNATURE_____DATE_____

ELIGIBILITY DETERMINATION (HOSPITAL USE ONLY)

PATIENT NAME _____ **MRN #** _____

Date Application was received: _____ Income Verified: ____YES ____NO

Account Number (s):_____

Total Charge Amount:_____

Reviewed By _____**Date** _____ **Mgr. Approval** _____ **Date** _____

CFO Approval (> $5,000) _____ **CEO Approval (>$10,000)** _____

_____APPLICATION APPROVED-FINAL DETERMINATION DATE: _____INITIALS_____
_____APPLICATION DENIED-FINAL DETERMINATION DATE: _____INITIALS_____
DENIAL REASON(S):

_____

_____

Date Applicant Notified: _____ IF APPROVED, Effective Date: _____