GOODALL-WITCHER
Hospital Authority

Clifton Medical Clinic
Goodall-Witcher Hospital
Goodall-Witcher Home Health Agency
Goodall-Witcher Nursing Facility
Goodall Witcher Fitness & Wellness Center

Dear Applicant,

Attached you will find the Goodall-Witcher Hospital Authority Financial Assistance Application. Completion of this application will enable us to consider your medical expenses at Goodall-Witcher Hospital Authority for financial assistance.

We understand your desire for privacy. Accordingly, the information you include with your application will be treated as confidential information. It will be available only to the Financial Assistance Program personnel on a need to know basis.

The application and documentation **must be returned within 15 days** to Goodall-Witcher Hospital Authority Eligibility Office. A self addressed, stamped envelope is provided for your convenience. If you have difficulty filling out the application or have questions regarding the program, please call 254-675-8322 (ext. 7861). Your cooperation is appreciated. The list of documentation that is needed is listed below:

◯ Proof of Income (Recent and Consecutive)
Employed: Two (2) months paycheck stubs or letter from employer
Self-Employed: Three (3) month ledger (gross income)
◯ IRS Form W-2/1099
◯2015 Full Tax Return
***If you cannot provide a tax return, you must provide a written letter explaining why you are unable to submit a tax return.**
◯ If not working, a letter of support from individual/company providing the support.
◯ Recent Supplemental Security Income (SSI)/Social Security Disability Income (SSDI)/Retirement Award Letter
◯Last 3 month's detailed bank statement for all checking/savings accounts (*ATM receipts will not be accepted*)
◯Photo ID
◯Food Stamp Award Letter (if applicable)
◯Other Resources (Child Support, 401K, IRA, Stocks, Bonds, etc.)

Thank you for choosing Goodall-Witcher Hospital Authority for your healthcare needs.

Sincerely,

Eligibility Specialist
Goodall-Witcher Hospital Authority

GOODALL-WITCHER
Hospital Authority

Application: Financial Assistance/Charity Care

Please print the name, date of birth, social security number and mailing address of the patient and who is responsible for this bill.

Last Name_____First Name_____Middle_____

Street Address_____

City_____ State_____ Zip_____Phone_____

Date of Birth_____ Social Security #_____

1. Is this application for future or past service? Future___ Past___ Date of Services____

2. Has anyone in your household applied for County Indigent Health Care Program, Children's Health (CHIPS), or Medicaid?

Yes___ No___ Who? _____

When? _____ What is the status? Pending____ Denied_____ Reason_____

3. Is anyone in your household pregnant? Yes____ No____

4. Has anyone in your household served in the military? Yes___ No ____ Who? _____

5. Have you ever filed a worker's compensation or motor vehicle accident claim? Yes___ No___ Date_____

6. Is anyone in your household eligible for Social Security benefits? Yes___ No___ Who? _____

7. Is anyone in your household covered by health insurance or a health savings account (HSA)? Yes____ No___

Who_____

8. Does anyone else claim you on their income tax return Yes___ No___ Who? _____

List all dependents, including your spouse:

Name	Date of Birth	Relationship	Applying for assistance? Y/N

MONTHLY INCOME

Do you have an income? _____ Amount $_____

Does your spouse have an income? _____ Amount $_____

If yes, you must provide recent pay stub, receipts if self-employed, proof of public assistance payments, Social Security, unemployment, workmen's compensation, child support, alimony, etc. **Documentation is required.**

Office use only: Date Received_____Date Approved_____Date Denied_____

ASSETS

NOTE: Married person should include spouse's financial information.

Cash on hand and/or in banks……$_____

(Checking $_____ Savings $_____ Credit Union $_____)

Automobiles, boats, motor homes etc…….. $_____

Real estate (Property) $_____ Mobile home? If yes, what year: _____$_____

All other assets not specified above: please include description and value below:

Total Assets……$_____

Household Expenses

Monthly Rent Payment $_____or Mortgage Payment$_____Mortgage Loan Balance $_____

Property Tax amount not included in payment amount above $_____Value of home $_____

Do you own property other than primary residence Yes____ No____ If yes, what is value $_____

Monthly loan payment $_____ Paid to_____For_____

Medicare Part D deducted from Social Security Check Yes____ No____ Amount $_____

Utilities $_____ Insurance $_____ Living (gas, food, clothes) $_____ Other:_____ $_____

Alimony/Child Support $_____ Health Insurance $_____ Child Care $_____ Other:_____ $_____

Assignment of Rights

By signing below I authorize the request for my credit report and/or tax return. I understand that a tax return is needed to process this application and that more information may be requested before my eligibility can be determined. You may attach the documents and submit this application.

By signing below, I certify that all information I have submitted is true. I understand that any incorrect, incomplete or false information that I provide or someone else provides for me could cancel my application for financial assistance.

All adult household members who sign below authorize the release of any medical, financial or employment information which relates directly to their health care or to their financial assistance eligibility. This information may be released to any health care provider from whom household members have sought health care services or financial assistance. All information provided will remain confidential under the provisions of HIPPA federal regulations. Elective procedures may not be considered for assistance.

I agree that I will repay the full assistance award if I receive payment of any kind for the medical services covered by this application, for example insurance payments, government program payments, award from a lawsuit or any other payment.

If I receive Financial Assistance, I agree to inform Goodall-Witcher Hospital Authority of any changes which could impact eligibility, including changes to family size, income and health insurance coverage. I understand that if my/our medical situation changes so that I/we might be eligible for a public assistance program, I will need to apply to that program and provide proof of application.

_____ _____

Applicant Signature Date Co-Applicant Signature Date