Financial Assistance Application - Harrison Community Hospital

Patient Name: _____ Date of Application: _____

Date of Birth: _____ Account Number(s): _____

Street Address: _____

City: _____ State:_____ Zip Code:_____

Phone Number: _____ Alternate Phone:_____

Are you or your spouse a Wheeling or Belmont Community Hospital employee? No Yes

Were you an active Medicaid recipient at the time of your service? No Yes

Please indicate Medicaid ID number: _____

Were you an active recipient of Disability Assistance at the time of your service? No Yes

Did/do you have health insurance (other than Medicaid)? No Yes

Please provide the type of insurance and your ID number: _____

If no insurance coverage, please explain: _____

Are you homeless or have you received care from a homeless clinic? No Yes

Do you participate in the Women's, Infants, and Children's program (WIC)? No Yes

Are you currently living in low income/subsidized housing? No Yes

Patient is deceased with no known estate. No Yes

Other (please describe)_____

Savings Account with: _____ Current Balance: _____
Checking Account with: _____ Current Balance: _____
Other: CDs, IRAs, Stocks, etc: _____ Current Balance: _____

Please provide the following information for all the people in your immediate family who reside in your home. Family shall include the patient(s), their spouse, and all children, natural or adoptive, under the age of eighteen (18) who live in the home.

First Name	Middle	Last	Relationship to patient	Age	Gross Income for last 12 months

Total persons in family:_____ Total Family income: $_____

If you claim ($0) income, please explain your means of support (i.e. friends, family)_____

Signature:_____ Date:_____