BOONE MEMORIAL HOSPITAL, INC.
Application for Financial Assistance for Hospital Charges
Information and Instructions

INSTRUCTIONS

As part of its commitment to its mission and community, Boone Memorial Hospital, Inc. (BMH) elects to provide financial assistance to individuals who satisfy certain income requirements.

To determine whether you may qualify for financial assistance, BMH needs to obtain certain financial information as outlined within this application. Your cooperation will allow BMH to give all due consideration to your request for financial assistance.

Please provide the information requested within this application and return the completed form and income verification to the following address:

Boone Memorial Hospital, Inc.
Attn: Patient Financial Services
701 Madison Avenue
Madison, WV 25130

Section A: Income

In Section A of the Financial Assistance Application, please indicate the dollar amount each listed person receives as income and whether the amount represents hourly, weekly, monthly, or yearly income.

Section B: Family Members

Section B of the Financial Assistance Application requests information on the number of persons in the patient's household. This number should include the patient, the patient's spouse and the patients' dependents. If the patient is a minor, please include the patient's mother and father and any dependants of the patient's mother and father.

Section C: Income Verification

In order to consider your request for Financial Assistance, verification of your income is required. Please provide BMH with a copy of one of the following (listed in order of preference): pay check remittance; IRS Form W-2, Wage and Tax Statement; individual tax return; employer verification; Social Security, Workers' Compensation, or Unemployment Compensation determination letters; proof of participation in governmental assistance programs such as food stamps, CDIC, Medicaid or AFDC; or Bank Statements.

If you are unable to provide one of the sources of income documentation listed above, please provide a written explanation in Section C of the Financial Assistance Application as to why income documentation is not available.

Physician Services

Some of the physicians providing services at BMH are not employees of the hospital. You may receive separate bills from your private physician and/or from other physicians whose services your hospital visit required, such as radiologist professional fees for charges associated with reading x-rays. For questions regarding these bills, or to make payment arrangements for these physician services, please contact the individual physicians' office(s).

If you require any assistance in completing this application, please contact BMH at (304) 369-1230, Monday through Friday, between the hours of 8:30 a.m. and 4:00 p.m.

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Patient Name _____ Patient Account Number _____

Social Security Number _____ Birth Date (Month/Date/Year) _____ Telephone Number _____

Patient Address _____ City _____ State _____ Zip Code _____

Employer (Name, Address and Telephone Number) (If unemployed, list previous employer information) _____

Spouse Name (or Father and Mother if Patient is a Minor) _____ Social Security Number _____

Spouse Employer (Name, Address and Telephone Number) (If unemployed, list previous employer information) _____

A. *Income:* Please provide the income for each of the following persons in your household.

		Circle One			Circle One
Patient	$_____	Hr/ Wk/ Month/ Year	Patient's Father (If patient is a minor)	$_____	Hr/ Wk/ Month/ Year
Spouse	$_____	Hr/ Wk/ Month/ Year			
Total Income	$_____		Patient's Mother (If patient is a minor)	$_____	Hr/ Wk/ Month/ Year

B. ***Family Members:*** Please provide the number of people in the patient's household. _____

C. *Income Verification:* Please provide one of the following types of documentation to verify your income (listed in order of preference)

1) Paycheck Remittance
2) IRS Form W-2
3) Tax Return
4) Employer Verification
5) Social Security, Workers' Compensation Or Unemployment Compensation Determination Letters
6) Proof of Participation in Governmental Assistance programs such as food stamps, CDIC, Medicaid or AFDC
7) Bank Statements
8) Other, Please Describe

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available.

_____

_____

D. *Assets and Other Resources:*

Do you have any assets or other resources available to you? (Examples include savings accounts, trusts, stocks, bonds, Retirement accounts, mutual funds, etc.) ☐ Yes ☐ No If Yes, Current amount available: $_____

Do you have medical insurance? ☐ Yes ☐ No If Yes, please list provider name: _____

Do you have a Health Savings Account? ☐ Yes ☐ No If Yes, Current amount available: $_____

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I understand that Boone Memorial Hospital, Inc. ("BMH") may verify the financial information contained in this Application for Financial Assistance for Hospital Charges ("Application"). By my signature below I hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided on this Application. I also authorize BMH to request reports from credit reporting agencies and the Social Security Administration. I certify that the statements made in this Application are true and correct, to the best of my knowledge and belief, and are made in good faith. I am aware that falsification or misrepresentation of information on this Application may result in denial of financial assistance.

I further understand that the physicians providing services are not employees of the hospital. I understand that I will receive separate bills from my private physician and from other physicians whose services I required and that any financial assistance granted by BMH excludes those physician charges.

_____ _____
Signature of Patient, Immediate Family Member or Patient Representative — Relationship to Patient (If Applicable)

_____ _____
Printed Name — Date

For Hospital Use Only:

Income Verification:

Name of Person Contacted: _____ Date: _____

Information obtained: _____

_____

BMH Employee signature: _____ Date: _____

Name of Person Contacted: _____ Date: _____

Information obtained: _____

_____

BMH Employee signature: _____ Date: _____

Notes regarding number in household: _____

_____

If patient / responsible party is unable to sign the application, state why:

_____

_____

Other notes: _____

_____