Penn Medicine
Lancaster General Health

555 N. Duke St.
P.O. Box 3555
Lancaster, PA 17604-3555

Date:

Name
Address
Address

Guarantor #

Dear ,

Attached please find a copy of the Lancaster General Health Application for Financial Assistance. The completion of the application is an important first step in the determination of your family's eligibility for financial assistance.

Lancaster General Health will retain copies of all patient information used to determine financial need, as required by federal and state law. **Please be sure to make copies of all necessary documents before returning to Lancaster General Health as we will not return your originals.**

You may receive patient bills until your application has been processed. **Please complete all questions on this application and return within 14 days. Failure to complete all questions and provide all documentation may result in your application being denied.**

Federal and state laws require all health care providers to seek payment for care provided, while also providing opportunities for financial assistance for those individuals who qualify. It is important that a completed application be submitted for consideration as unpaid bills may be turned over to a collection agency.

If you have any questions regarding the completion of this application, please contact a Financial Counselor at 717-544-1957. Information is also available on our website at www.LGHealth.org/Financial-Assistance.

Sincerely,

Financial Counseling Team

Please mail completed application along with documentation to:

Lancaster General Health
Attn: PFS, Customer Service Dept
FA Program
PO Box 3555
Lancaster, PA 17604-3555

MRN: _____ CSS: _____

APPLICATION FOR FINANCIAL ASSISTANCE

Please verify the information below is correct and attach all requested documentation. Failure to sign and return application with ALL REQUESTED DOCUMENTS will result in the denial of your application.

Patient Information

Patient Name: _____ Date of Birth: _____ Phone: _____

Address/City/State/Zip: _____

USA Citizen? Y / N Undocumented? Y / N Pregnant? Yes / No

Name of Household Member	Relationship	Date of Birth	Ins Name & I.D. #
1.			
2.			
3.			
4.			
5.			

Please return the following

	Federal Tax Return, 1040		Child or Spousal Support
	30 days of pay stubs		Cash Assistance/SNAP Award Letter
	30 days of **all** bank statements - Checking - Savings		Short/Long Term Disability Award Letter
	Social Security Award letter or 1099		Pension/Retirement
	Statement of Support with Photo I.D.		Workers Compensation Award Letter
	Unemployment Letter		Loan "Due on Demand"

List any other financial considerations or relevant information that may help in making a decision:

_____

Certification

I certify that the information contained in this financial statement is true and accurate, and I understand that any false information may result in legal action against me. I understand that Lancaster General Health reserves the right to verify any financial and/or credit related information contained in this form. Lancaster General Health will retain copies of all patient information used to determine financial need, as required by federal and state law. I further certify that I understand there is now a federally mandated insurance program available through the Affordable Care Act. Failure to enroll and remaining uninsured may affect the level of financial assistance offered by Lancaster General Health.

□ **I DO** □ **I DO NOT** (check one) give permission to Lancaster General Health to notify my attending physician(s) of its determination in the event this request for financial assistance is approved by Lancaster General Health, in whole or in part. I understand that any decision to waive my physician fees is the responsibility of my attending physician(s), and not Lancaster General Health.

_____ _____

Signature of Responsible Person Date