Geisinger

FINANCIAL APPLICATION

Proof of Income Must accompany this application (2 pay stubs or 1040)

Do not include original copies as they will not be returned

Section 1- Patient Information

1. Patient Name	2. Medical Record Number:
(Last) (First) (MI)	
3. Date of Application	4. Additional Medical Record Numbers this application covers:
5. Street Address:	6 Telephone Number:
7. City, State, Zip Code:	8. *Family Size:

***Family size includes self, spouse, and any minor children. A pregnant woman is counted as two family members.**

9. U.S. Citizenship? YES or NO	10. Social Security Number or Individual Taxpayer Identification Number:

11. Salary/Wages before Deductions: $_____

Include copies of two pay stubs to support salary/wages or current IRS 1040 filing

12. Primary Health Coverage: **(If Medicare, Veterans Affairs or Uninsured, must include Pennsylvania Medical Assistance determination)**

13. Does the household have assets in excess of $5,000? **(Yes/No)**

If yes, please list the assets and provide statements

Assets Include: (Checking/Savings; Money Market/CD/Stocks/Bonds; Property (exclude primary residence); Other)

Patient or Guarantor Signature:	Date:

Mail Application and supporting documentation copies to: Geisinger Uncompensated Care Service 49-38
100 North Academy Ave
Danville, PA 17822-4938

Section 2 – Office Use Only

Received Date:	Review Date:
Verified Income:	Federal Poverty Level:
Approved (circle): YES NO (Select reason for denial)	Reasons for Denial: _____ Applicant Over Income _____ Applicant did not supply Income Documentation _____ Applicant did not supply Medicaid Determination Other:_____
Total Adjustment:	Approver Level:

Geisinger Title	Signature:	Date:
Service Line Specialist		
Supervisor		
Manager		
Director		
Associate Vice President		
Vice President		