BUTLER MEMORIAL HOSPITAL

FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME: _____

DATE OF SERVICE: _____

ACCOUNT NUMBER: _____

Listed below are the documents that are needed to complete your Financial Assistance Application. This application MUST be completed and returned within **30** days to Patient Financial Services.

Please provide the following documents to verify income:

_____1040 TAX RETURN (MOST RECENTLY FILED) (FRONT PAGE OF FEDERAL INCOME TAX RETURN-INCLUDES NUMBER OF DEPENDENTS CLAIMED)

_____SOCIAL SECURITY BENEFITS FOR THE CURRENT YEAR (COPY OF BANK STATEMENT IF DIRECTLY DEPOSITED)

_____UNEMPLOYMENT BENEFITS (COPY OF UNEMPLOYMENT DETERMINATION NOTICE)

_____CHILD SUPPORT PAYMENTS

_____PAYSTUB(S) LAST 30 DAYS

_____PENSION (COPY OF BANK STATEMENT IF DIRECTLY DEPOSITED)

_____DISABILITY/WORKERS COMPENSATION

_____ALIMONY

_____PROOF OF ANY OTHER SOURCES OF INCOME

_____MEDICAL ASSISTANCE DETERMINATION LETTER

_____NUMBER OF DEPENDENTS CLAIMED FOR TAX PURPOSES

SIGNATURE_____WITNESS_____

FOR HOSPITAL USE ONLY:

INCOME PREVIOUS TAX YEAR: _____%APPROVED_____

INCOME CURRENT TAX YEAR: _____APPROVED BY_____

PLEASE SIGN AND RETURN FORM AND DOCUMENTS TO PATIENT FINANCIAL SERVICES AS SOON AS POSSIBLE. ANY QUESTIONS PLEASE CONTACT OUR OFFICE AT 724-284-4460 MONDAY THROUGH FRIDAY 8:00AM TO 4:00PM. YOU CAN ALSO EMAIL YOUR APPLICATION TO patientfinancialservices@butlerhealthsystem.org OR MAIL YOUR APPLICATION TO BUTLER MEMORIAL HOSPITAL ONE HOSPITAL WAY, BUTLER, PA 16001 ATTENTION PATIENT FINANCIAL SERVICES.