

PO BOX 2353  
Harrisburg, PA 17105-2353



Patient name  
Patient address  
Patient address

Date:  
Patient Name:  
Medical Record #:

Dear :

Attached is the financial aid application as requested. To avoid processing delays with your application, please use the checklist to verify all information has been completed or attached as required.

- Complete the financial aid application, **sign and date**. Use N/A if applicable.
- Copy of last filed federal tax return with all schedules.
- If you do not file please provide a letter stating the reason, sign and date the letter

**Proof of income is important. Applications without income information will be denied.**

- Proof of monthly household income for all members of household:
  - Current and complete bank statement for checking, savings, business accounts showing all transactions for the last 30 days as of the date of this application
  - Current pay stubs for the last 30 days as of the date of this application

You must send us copies if you get any of these benefits:

- Notice received from Social Security Administration indicating current year monthly benefit
- Any pension payments that are received monthly
- Notice received from Bureau of Unemployment for weekly benefit
- Current denial or approval from Medical Assistance/Medicaid if you have applied
- Copy of denial or exemption letter from the Marketplace, HealthCare Exchange
- Copy of alimony or child support agreement, letter, check or bank statement with deposit
- If you have no income, the person who helps you with daily living expenses must write a letter describing the dollar amount of assistance they provide and the reason.

Your aid may be reduced or denied for refusal to enroll in a subsidized health plan due to the expanded Medicaid program in Pennsylvania.

Call us if you have questions at 717-231-8989 or 1-877-499-3899 (toll-free), option 3.

Sincerely,  
Patient Financial Coordinator



Patient Financial Coordinator  
UPMC in Central Pa  
P.O. Box 2353  
Harrisburg, PA 17105-2353

RETURN TO:

**FINANCIAL AID APPLICATION**

If you have any questions, please call Patient Financial Support Services 717-231-8989 or 1-877-499-3899.

**Patient's Information**

_____ Last	_____ First	_____ MI	_____ DOB
_____ Address	_____ City	_____ State	_____ Zip
_____ SSN #	_____ Phone #		

**Guarantor's Information (If Different Than Patient)**

_____ Last	_____ First	_____ MI	_____ DOB
_____ SSN #	_____ Phone #	_____ Relationship	

**Household Members:**

Name	Relationship	DOB	UPMC in Central Pa Outstanding bills (Y/N)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Household Income (PROVIDE PHOTOCOPIES OF PROOF OF INCOME FOR LAST 30 DAYS)**

	<u>Employer/Occupation</u>	<u>Monthly Gross Amount</u>
Wages: Self	_____	_____
Spouse	_____	_____
Others	_____	_____
Self Employment	_____	_____
Pensions	_____	_____
Social Security/SSI	_____	_____
Unemployment or Workers Comp.	_____	_____
Child/Spousal Support	_____	_____
401 K Plans/Other Annuity Payments	_____	_____
Veteran's Administration (VA Benefits)	_____	_____
Public Assistance/Cash Assistance	_____	_____
Income from Dividends, Interest, Rent	_____	_____
<b>TOTAL INCOME</b>		<input type="text"/>

**Expenses (NO PHOTOCOPIES NEEDED PLEASE ESTIMATE THE AVERAGE MONTHLY AMT)**

	Creditor Name	Monthly Payment	Acct Balance
Mortgage/Rent	_____	_____	_____
Auto Loans/Leases	_____	_____	_____
Credit Cards	_____	_____	_____
	_____	_____	_____
Bank Loans	_____	_____	_____
Taxes Personal		_____	
Real Estate		_____	
Medical Bills	_____	_____	_____
	_____	_____	_____
Prescription Medicines		_____	
Spousal Support		_____	
Child Care/Support		_____	
Phone (including cell)/	Cable/ Internet	_____	
Electric		_____	
Water		_____	
Gas/Oil		_____	
Sanitation		_____	
Insurance Car		_____	
Individual		_____	
Home		_____	
Health		_____	
<b>Total Expenses</b>			

**Assets (PROVIDE PHOTOCOPIES OF FINANCIAL INSTITUTION STATEMENTS LAST 30 DAYS)**

	Bank Name	Balance of Account (\$)
Checking Account	_____	_____
	_____	_____
Savings Account	_____	_____
	_____	_____
Christmas/Vac. Club	_____	_____
Certificate of Deposit	_____	_____
Money Market Acct.	_____	_____
Stocks/Bonds Health	_____	_____
Savings Acct. Trust	_____	_____
Fund/Annuities	_____	_____
Other Assets	_____	_____

**I certify that the information contained in this application is true and complete.**

Signature of Patient \_\_\_\_\_ Spouse \_\_\_\_\_  
 or Guarantor Date: \_\_\_\_\_ Date: \_\_\_\_\_