

**Roane General Hospital
200 Hospital Drive
Spencer, WV 25276**

For assistance in completing application, contact the Patient Financial Counselor at
304-927-6883

Financial Assistance Application

Roane General Hospital (RGH) will grant financial assistance to qualified patients on the self-pay portions of their accounts as long as resources are available to finance such care.

In order to receive financial assistance the application must meet the following eligibility requirements:

1. Care rendered **must not** be for experimental, cosmetic, or elective reasons and must be medically appropriate;
2. The applicant's financial situation is consistent with the provision of charity care;
 - ✓ Assets are those necessary for the patient's daily living
 - ✓ Income does not exceed the amount needed to meet patient's daily living expenses; and
3. The applicant is **not** eligible for federal or state assistance (Medicaid, Chips, VA); or
4. There is no other source of payment for the patient's medical bill; for example, medical insurance coverage; and
5. Bad Debt Accounts are **not** eligible for financial assistance (Charity Care).
6. For patients who have multiple visits yearly, an application will be required every six months to ensure all information is accurate.
7. Medicaid Spin Down will **not** be eligible for financial assistance (Charity Care).
8. Skilled, Intermediate and Swing admissions are not eligible for the Financial Assistance Program.

ATTACHMENTS:

All applicants must attach the copies of the following. **Incomplete applications will be denied.**

1. Federal or State tax returns for last year if applicable, or
2. Copy of most recent social security related income amount if applicable, or
3. Pay stubs for three (3) month for all family unit members who are employed, and
4. Proof of any other source of income.
5. All bank statements for three (3) months, and
6. Copy of denial letter from Medicaid.
7. Roane County Family Health Care Reduced Fee Card (if applicable).
8. Any other information deemed necessary by RGH;
 - ✓ Proof of no income for family unity members as applicable
 - ✓ Proof of monthly pharmacy expenses
 - ✓ Proof of expenses, assets, liabilities as described, if applicable

| FOR HOSPITAL USE ONLY | |
|--|--|
| APPROVED/DATE: ____/____/____ REJECTED: ____/____/____ INCOMPLETE: ____/____/____ | |
| Expiration Date: ____/____/____ (VALID 6 MO FROM APPROVAL DATE) | |
| ****Does the applicant appear to qualify for CHIPS or Medicaid? If yes, refer to appropriate agency. FS Clerk Name: _____ Date: _____ | |
| Approved By: _____ Date: _____ | |
| Remarks: _____ | |
| <i>Application must be approved by Director of Patient Financial Services or Authorized Personnel</i> | |

Roane General Hospital
200 Hospital Drive
Spencer, WV 25276
Attention: Patient Financial Services

FINANCIAL ASSISTANCE APPLICATION

- () Financial Assistance - Roane General Hospital Services
- () Financial Assistance - Roane General Medical Clinic Services
- () Financial Assistance - Roane General Medical Associates Services
- () Financial Assistance - Southern Roane Medical Clinic

Today's Date: _____

Please answer all questions completely and to the best of your knowledge in order to prevent delaying this application. Copies of income, countable resource and expenses MUST be attached or application will be rejected as incomplete.
 IF ALL AREAS ARE NOT COMPLETED, THE APPLICATION WILL BE REJECTED.

Patient Name: _____ Phone #: _____

Address (including directions: if PO Box include route number):

Birthdate: ____/____/____ Age: _____ Marital Status: _____

West Virginia Resident (Y/N): _____

County of residency: _____

| Account Number | Amount |
|--------------------------------------|--------|
| | \$ |
| | \$ |
| | \$ |
| | \$ |
| | \$ |
| | \$ |
| | \$ |
| | \$ |
| | \$ |
| Total Financial Assistance Requested | \$ |

Section 1 - Household & Employment Information

List all persons living in household.

| NAME & Social Security Number | RELATIONSHIP / AGE | INSURANCE COVERAGE |
|-------------------------------|--------------------|--------------------|
| Name: SS#: | | |
| Name: SS#: | | |
| Name: SS#: | | |
| Name: SS#: | | |
| Name: SS#: | | |
| Name: SS#: | | |
| Name: SS#: | | |

Was this visit to the hospital in any way related to an on-the-job injury or occupational disease? _____

If yes, please explain _____

Current Employer: _____ Phone #: _____

Address: _____

Position Held: _____

Dates of Employment: From ____/____/____ through ____/____/____

If you have been approved by Roane County Family Health Care "Reduced Fee Card", please stop here and complete page 7, section 5.

Monthly Income & Expenses

Section 2 - Monthly Household Income

| Household Monthly Income SUPPLY COPIES OF SUPPORTING DOCUMENTS | | | |
|---|----|------------------------|----|
| Wages: | \$ | Food Stamps: | \$ |
| Tips: | \$ | Retirement: | \$ |
| Alimony/Child Support: | \$ | Unemployment: | \$ |
| Social Security: | \$ | General Relief | \$ |
| Pensions: | \$ | Strike Benefits | \$ |
| Military Family Allotments: | \$ | Income from Dividends: | \$ |
| Income from Interest: | \$ | Income from Rent: | \$ |
| Income Other: (explain) | \$ | | |
| Total Income: | \$ | | |

Section 2: Monthly Household Expenses

| Household Monthly Expenses SUPPLY COPIES OF SUPPORTING DOCUMENTS | |
|---|----------------|
| Description | Monthly Amount |
| House Rental / Payment | |
| Food | |
| Car Payment | |
| Car Operating Expenses | |
| Phone | |
| Electric | |
| Gas | |
| Water | |
| Sewer | |
| Other Medical | |
| Other (Specify) | |
| Total Expenses | |

Section 3 - Assets

| Assets | |
|------------------------------|-----------|
| House / Land Value | \$ |
| Car/Truck Value | \$ |
| Name and Address of Bank | |
| Savings Account Amount | \$ |
| Checking Account Amount | \$ |
| Stocks/Bonds/CDs/IRAs | \$ |
| Guns/Jewelry over \$500.00 | \$ |
| Retirement Funds/Pensions | \$ |
| Cash Value of Life Insurance | \$ |
| Other Assets (Specify) | \$ |
| Other Assets (Specify) | \$ |
| Other Assets (Specify) | \$ |
| Total Assets | \$ |

Section 4 - Applicant Other Than Patient

If applicant is deceased, please complete the following:

1. Date patient expired ____/____/____
2. Is there a surviving spouse? (Y/N) _____. If yes, name and address of surviving spouse:

3. Is there an estate? (Y/N) _____
4. How was this verified? _____
5. Name of persons making application: _____
6. Relationship to patient: _____

Section 5 - Authorization and Certification

State of West Virginia
County of Roane to Wit:

I swear that the above information is correct and complete. Further, I will make an application for any assistance (Medicaid, Medicare, Insurance, etc), which may be available for payment of my charges. I will take any action reasonable necessary to obtain such assistance and will assign or pay to RGH / RGMC / RGMA / SRMC the amount recovered for RGH / RGMC / RGMA / SRMC charges. I authorize Roane General to contact the employers and institutions on this application to verify its accuracy. I further authorize the employer/institutions to release such information to Roane General Hospital.

Patient/Applicant Signature

Taken, subscribed and sworn to before me on this ____ day of _____, 20____, by _____, Notary Public.

My commission expires:

Notary Signature

Date

Completed By:

Financial Counselor