The Guthrie Clinic

Financial Assistance Application

Please refer to Attachment I of this Application for instructions on completing this Application. If you have any questions or need assistance, please contact a financial counselor at (570) 887-2051.

1. Name of Applicant:
   (Guarantor on Account) _____

2. Name of Patient: _____

3. Relationship to Applicant: _____

4. Address: _____

   _____

   _____

5. Telephone Number: _____

6. Number of Dependents: _____
   (Number of members in the household)

7. County: _____

8. Number of Months in this County: _____

9. Social Security Number of Applicant: _____

10. Social Security Number of Patient: _____

11. Date of Birth of Applicant: _____

12. Date of Birth of Patient: _____

13. Medicaid Eligible? ____ Yes ____ No

14. Health Insurance? ____ Yes ____ No

    Insurance Company: _____

15. Employer Health Plan? ____ Yes ____ No

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Patient Name: _____ Account Number: _____ Date: _____

16. Sources of Incomes

Head of Household:

Current Employer: _____

Address: _____

_____

_____

Telephone Number: _____

Other Income Source _____

Other Income Source _____

Spouse:

Current Employer: _____

Address: _____

_____

_____

Telephone Number: _____

Other Income Source _____

Other Income Source _____

(List all employers. If additional space is required, please attach a separate sheet of paper.)

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Patient Name: _____ Account Number: _____ Date: _____

Household employment Income

17. Monthly Income:

	Patient/Guarantor	Spouse	Other
Gross salaries and wages	$	$	$
Social Security	$	$	$
Pension	$	$	$
Workers Compensation	$	$	$
Unemployment	$	$	$
Business income	$	$	$
Rental income	$	$	$
Investment income	$	$	$
Alimony	$	$	$
Child Support	$	$	$
Other (list source)	$	$	$
Other (list source)	$	$	$
Total income all sources	$	$	$

18. Monthly Expenses:

	Patient/Guarantor	Spouse	Other
Pharmacy costs	$	$	$
Medical costs	$	$	$
Other medical bills	$	$	$
Total expenses all sources	$	$	$

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Patient Name: _____ Account Number: _____ Date: _____

19. OTHER SUPPORTING DOCUMENTS REQUIRED:

_____Bank Statement (Most Recent)

_____Investment Account Statements (All Accounts)

_____Income Verification (current month's paycheck stubs, Social Security statement, letter from employer…etc.)

_____Receipts (medical expenses paid including pharmacy costs)

_____Proof of Medicaid Application if applicable for incomes less than 150% of Federal Poverty Level.

_____Employer Health Plan Description (If applicable)

_____Health Savings Account (HSA) Statement showing current balance. (If applicable)

In order to be eligible, a completed application AND all required documents must be provided in addition to meeting all eligibility criteria. Please disregard billing statements while your application for financial assistance is pending

I UNDERSTAND THAT THE INFORMATION THAT I SUBMIT IS SUBJECT TO VERIFICATION BY THE GUTHRIE CLINIC ENTITIES AND SUBJECT TO REVIEW BY OTHERS AS REQUIRED. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I AGREE TOINFORM THE GUTHRIE CLINIC WITHIN 30 DAYS OF ANY CHANGES IN INCOME, EXPENSES, INSURANCE STATUS OR FAMILY STATUS.

Patient Signature: _____ Date: _____

Printed Name of Person Completing Form: _____
(If other than patient)

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Attachment I

Instructions for Completing the Financial Assistance Application

1. Name of Applicant (Guarantor of Account)
The name of the person who is responsible for paying the patient's bill.

2. Patient Name:
All family members who have charges on their account(s) must be listed on the Application.

3. Relationship to applicant:
Family members must have one of the following relationships with the responsible party:

- Spouse
- Child
- Adopted child
- Grandchild
- Step-grandchild
- Parent
- Grandparent

4. Address:
The applicant's address refers to the residence of all family members included in the application. All family members covered by this application must reside at this address. This address cannot be a business address or an empty lot. For non-emergent care services, a patient has to be a resident for six (6) months or more in The Guthrie Clinic Service area, which consists of the following twelve counties: Bradford, Sullivan, and Tioga in Pennsylvania and Allegany, Chemung, Livingston, Ontario, Schuyler, Steuben, Tioga, Tompkins, and Yates in New York.

5. Telephone Number:
Telephone number where applicant can be reached.

6. Dependent Status: (Number of Members in the Household)
Family members must receive at least fifty (50) percent of their support from the responsible party to be included in the family size calculation. Proof of support includes the family members being listed on the prior year's tax return as a dependent, canceled checks, or copies of many orders for support expenses.

7. County:
County where Applicant resides.

8. Number of Months in this County:
Number of months that Applicant has resided in above county.

9&10 Social Security Number of Applicant and of Patient:

Include the social security number(s) of the applicant, and if different, of patient. If the applicant does not have a social security number, proof of applying for a social security number must be received at time of application.

11&12 Date of Birth of Applicant and of Patient:

Include the applicant's date of birth, and if different, of patient.

13. Medicaid or Other Assistance Program Denial:

Mark the "Yes" line if any of the family members qualify. Applicants must provide proof of Medicaid application from his/her home state for income levels less that 150% of the Federal Poverty Level. Mark the "No" line if the family members clearly are not eligible for Medicaid and continue completing the application.

14. Health Insurance Information:

Patients who have access to other medical care (e.g. primary and secondary insurance coverage) must utilize and exhaust their benefits before qualifying for the financial assistance program; however, the program is available to assist patients with co-insurance, deductibles, or co-payments (excluding co-insurance, deductibles, or co-payments required by Medicaid or other need-based programs).

Applicants must provide all information related to the insurance policy and attach a copy of the policy or insurance card to the application. The information required to submit is as follows:

- The name of the insurer
- The address where the medical claims forms must be submitted.
- The policy number.
- Any other information determined to be necessary.

If insurance is acquired in the six-month eligibility period, this information must be immediately communicated to the Financial Assistance Office. Failure to provide this information will result in retroactive ineligibility and patients will become responsible for all changes incurred while the insurance was in place.

15. Employer Health Plan:

All applicants may be required to provide descriptions of their employer's benefit programs. Both the head-of-household and spouse need to provide details concerning their employer's benefit program and enrollment status.

16. Determining Sources of Income:

List the income sources for all family members over the age of 18 (income from minor is not counted). Applicants must list the full names, phone numbers, and addresses of all employers and sources of disability and retirement payments. A separate sheet of paper may be used, if necessary.

For purposes of the financial assistance program, all sources of income will be included in the calculation of financial need including without limitation: employment income, unearned income, self-employment income, and in-kind income (see definitions below).

17. Monthly Income:

Employment Income:
Employment income is income earned (including overtime and bonuses) for providing services to another individual or entity. Employment income for the financial assistance program does not include self-employment income.

Employment income will be calculated as follows:

All adult (over the age of 18), employed family members, including the applicant, must provide documentation of current monthly earnings history, evidence by either pay stubs or a letter signed by the employer on the official letterhead of the employer in order to document income. Gross income is the total earnings before any deductions. Employment income will consist of the annualized current earnings based on the pay stub or employer letter. If circumstances have changed that require the use of the lower figure (i.e., the applicant took a lower paying job), these circumstances must be documented in the file.

Unearned Income:
Unearned income consists of gross income received from sources other than employment. The following are considered to be sources of unearned income:

- Unemployment compensation.
- Supplemental Security Income (SSI) except for SSI benefits received for minors, including cash received from SSI benefits for applicants. In order to exclude SSI benefits received for minors, the applicant must provide proof that the Social Security Benefit checks include the child's name. If the checks do not include the child's name, they will be included as unearned income for purposes of this application.
- Payments from retirement plans and/or pensions. Retirement plans and pensions come in many forms. Some examples are: Tax Sheltered Annuities, Deferred Compensation, Individual retirement Accounts (IRSs), 401(k) plans, and Social Security Benefits.
- Commissions, bonuses, gifts and tips. Include amounts from commissions, bonuses, gifts, and tips when calculating unearned income on the application.
- Court-ordered alimony-received.
- Income from trust accounts or annuities.
- Income from rental properties (including boarding and lodging).
- Interest income, including earnings from savings accounts, stocks, bonds, and similar securities.
- Monetary gains from selling assets.
- Cash surrender value of life insurance policies.

- Legal settlements.
- Tax refunds.
- Net gambling winnings.
- Work/study income.
- Dividends and royalties.
- Other investment income.

The following types of unearned income are not included in determining total income:

- College grants and scholarships.
- Child support and foster care payments. Many children receiving these payments are eligible for Medicaid. Therefore, a Medicaid denial is required before allowing these children to receive care under the financial assistance program.
- Food stamps.
- Assistance provided by another non-profit organization, if the assistance is need-based (i.e., the cost of meals at a soup kitchen.)
- College loans.
- Payments from credit life or credit disability insurance.
- Proceeds of loans.
- Disaster relief assistance.
- Moving expenses paid by employer for relocation.

Self-Employment

The net profit of a self-employed applicant will be calculated by deducting the cost of doing business from the gross income. The applicant must provide the necessary information and documentation/substantiation for each business owned. Applicants must provide bank statements for the past current month. Self-employment income will be calculated by taking the higher of either three months of gross deposits, less expenses, or the total net income from the current monthly net income.

Self-employment expenses include but are not limited to:

- Rent with respect to business premises.
- Wholesale cost of merchandise.
- Utilities.
- Taxes.
- Labor.
- Upkeep of necessary equipment.

Self-employment expenses do not include among others:

- Depreciation of equipment.
- Cost of payments on the principal of loan for capital assets or durable goods.
- Personal income tax payments, lunches, transportation to and from work, and other personal expenses.

In-Kind Income:
In-Kind Income is the value of goods and services received as a substitute for monetary payment. These goods and services are usually room (shelter) and board (food). For example, many ministers reside in rent-free houses furnished by their congregations. Live-in companions or domestics usually receive room & board in addition to their basic pay. Apartment complex managers frequently receive a rent-free apartment for managing the complex.

18. Paid Medical Expenses:
Applicants may deduct payments made or expected to be made during the current calendar year for c-payments, co-insurance, deductibles, or the patient responsibility portions of medical bills incurred for medical services received by themselves, their spouse, or their dependents. Medical bills incurred as a result of the patient using non-covered providers, services, or elective procedures are excluded from consideration. Documentation for expenses may be requested.

19. The following documents should be attached to the application:
- Bank and Investment Account Statements (Most Recent)
- Income Verification (current month's paycheck stubs, Social Security statement, letter from employer etc.)
- Receipts for medical expenses paid in the past 12 months including pharmacy costs. (Optional).
- Proof of Medicaid Application (if applicable for incomes less than 150% of Federal Poverty Level).
- Employee Benefits Plan Description (if applicable).
- Health Savings Account (HSA) Statement showing current balance (if applicable).

Applications should be mailed to the following address:

Attention: Financial Counselors
The Guthrie Clinic
Patient Financial Services Department
One Guthrie Square
Sayre, PA 18840
570-887-2051

Applications may also be submitted to a Financial Counselor or Patient Representative at any of our The Guthrie Clinic locations.