



Geisinger Health System  
100 N. Academy Ave.  
Danville, PA 17822-4938  
Tel: 800-640-4206

## Financial statement

Patient Name: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

Guarantor Name: \_\_\_\_\_

Guarantor Address: \_\_\_\_\_

Guarantor City, State, Zip: \_\_\_\_\_

Date: \_\_\_\_\_

Dear \_\_\_\_\_

Enclosed you will find a copy of a **Financial Statement Application**. Please complete the entire questionnaire. Depending on your family's financial situation, we may be able to offer partial or full relief of your medical bills. It is to your advantage to take the time to complete this financial questionnaire.

All documents on the financial statement checklist are required for processing. If any are not included, your application will be delayed or denied until the information is supplied.

Mail the financial statement, the financial checklist and all supporting documentation to:

**Geisinger Uncompensated Care Services 49-38**  
**100 N. Academy Ave.**  
**Danville, PA 17822-4938**

If you have any questions regarding this process, please contact our Customer Service Call Center at 800-640-4206. **Please allow at least 30 days for your application to be in our system before calling to check the status.**

Sincerely,

Uncompensated Care Department  
Geisinger Revenue Management

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For questions or information, call 800-640-4206 or, if you have registered for MyGeisinger, visit [mygeisinger.geisinger.org](http://mygeisinger.geisinger.org)

## Financial statement application

All lines must be filled in. If not applicable, write "N/A" on the line.

Blank lines will cause a processing delay.

Name: \_\_\_\_\_ Social security #: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Street address: \_\_\_\_\_ Medical record #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Phone: \_\_\_\_\_

How long at this address: \_\_\_\_\_ Total people in household: \_\_\_\_\_

Marital status:      Married      Divorced      Widowed      Single      Separated

Employer: \_\_\_\_\_

Spouse's name: \_\_\_\_\_ Spouse's social security #: \_\_\_\_\_

Names, dates of birth and medical record numbers of any other individuals to be included in this application:

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Medical record #: \_\_\_\_\_

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Reason applying for financial assistance:      Outstanding balance      Future service

List service & expected patient responsibility for future services:

## Household income

Applicant's gross yearly income: \$ \_\_\_\_\_ Spouse's gross yearly income: \$ \_\_\_\_\_

Other household members' combined gross yearly income: \$ \_\_\_\_\_

Additional yearly Income:

Social security: \$ \_\_\_\_\_ Pension: \$ \_\_\_\_\_ Disability: \$ \_\_\_\_\_

Child support: \$ \_\_\_\_\_ Alimony: \$ \_\_\_\_\_ Other (specify): \$ \_\_\_\_\_

Total household yearly income: \$ \_\_\_\_\_

Are you required to file federal income tax? Yes No

Have you applied for health coverage through the Marketplace? Yes No

Are you exempt from applying for coverage through the Marketplace? Yes No

## Assets

Bank name	Account type (Checking, savings, 401K, CD, IRA, other)	Balance

Home:      Own      Buying      Renting      Mobile home      Other \_\_\_\_\_

Car(s):      Own      Financed      Number of vehicles and years: \_\_\_\_\_

Other assets (Property or vehicle):

## Monthly expenses

Mortgage \$ \_\_\_\_\_ Heat \$ \_\_\_\_\_ Telephone \$ \_\_\_\_\_ Auto Ins. \$ \_\_\_\_\_  
Rent \$ \_\_\_\_\_ Electric \$ \_\_\_\_\_ Cable \$ \_\_\_\_\_ Life Ins. \$ \_\_\_\_\_  
Car \$ \_\_\_\_\_ Water/Sewer \$ \_\_\_\_\_ Food \$ \_\_\_\_\_ Health Ins. \$ \_\_\_\_\_  
Taxes \$ \_\_\_\_\_ Transportation \$ \_\_\_\_\_ Misc (explain) \$ \_\_\_\_\_

### Other expenses:

Type/Creditor	Monthly payment	Type/Creditor	Monthly payment

Total monthly expenses: \$ \_\_\_\_\_

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I certify to the truth of the above statement. I also hereby authorize Geisinger to investigate the references herein listed or statements or other data obtained from me or from any other person pertaining to my credit and financial responsibility.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Financial assistance checklist

To avoid processing delays with your application, please use this checklist to verify all information has been completed/attached as required.

All lines on the financial statement are completed. "N/A" is listed on the line if the item does not apply to you.

Most recent federal tax return, including all schedules, is attached and **signed** by all tax payers on form.

- » If you filed your taxes electronically, please sign the bottom of the form
- » If you are not required to file taxes, you have indicated so on the financial statement

Copies of the last three (3) months' checking and/or savings accounts statements are included (**must include all pages of the statement — summary pages will not be accepted**).

- » If no savings or checking accounts, you have indicated so on the financial statement

Proof of income from all sources for **all members** of the household is included.

- » **Employed:** Copies of the four (4) most recent consecutive pay stubs, or letter from employer on letterhead outlining same information
- » **Unemployed:** If no income exists, a notarized letter stating there is no income from any source
- » **Unemployment compensation:** Copy of eligibility determination letter, last four (4) pay stubs or copies of bank statement showing deposits
- » **Social security/disability:** Copy of current year's benefit determination letter
- » **Pension:** Copy of pension check, letter or bank statement showing deposits
- » **Alimony/child support:** Copy of agreement, letter, check or bank statement showing deposits

Most recent investment account statements are included.

- » 401K/403B
- » IRA
- » Tax-deferred annuity
- » CD
- » Other

Copy of medical assistance denial letter if you are enrolled in Medicare or you do not have health insurance is included (**denial must not be older than one year and must include all pages**).

Copy of denial or exemption letter from the Marketplace is included.

If married and currently separated, proof of separation is included.