BUTLER HEALTH SYSTEM

FINANCIAL ASSISTANCE APPLICATION

(for Butler Memorial Hospital, Clarion Hospital, and Butler Medical Providers)

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.

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 CURRENT YEAR (COPY OF BANK STATEMENT IF DIRECTLY DEPOSITED)

_____ UNEMPLOYEMENT BENEFITS (COPY OF UMEMPLOYMENT DETERMINATION NOTICE)

_____ PAYSTUB(S) LAST 30 DAYS

_____ PENSION (COPY OF BANK STATEMENT IF DIRECTLY DEPOSITED)

_____ DISABILITY/WORKERS COMPENSATION

_____ PROOF OF ANY OTHER SOURCES OF INCOME (ALIMONY, CHILD SUPPORT, RENTAL INCOME)

_____ MEDICAL ASSISTANCE DETERMINATION LETTER

_____ MOST RECENT CHECKING AND/OR SAVINGS ACCOUNT STATEMENT

_____ CERTIFICATE OF DEPOSIT (CD) STATEMENT

SIGNATURE _____

Please sign and return the form and documents as soon as possible to the address/email address below:

Butler Health System 724-431-2947: Mail application to Butler Health System, PO Box 447, East Butler, PA 16029, ATTN: Financial Clearance or email to BHSFinancialClearance@butlerhealthsystem.org

Please do not drop off applications in person.

For any other ancillary services or bills, please contact the phone number on the statement you receive.