Thomas Health System Financial Assistance Application Mail To: Thomas Memorial Hospital Attn: Patient Accounts Office 4605 MacCorkle Ave SW South Charleston, WV 25309 OR Return to a Registration Area at: Thomas Memorial Hospital or Saint Francis Hospital	Patient Acct: _____ Patient Name: _____ Patient SSN: _____ **Information needed to process Financial Assistance App** • 3 months of checking or other bank statements • 3 months of pay stubs • Most recent 1099 or W2 • Proof of social security, unemployment, workers compensation payments • Proof of paying/receiving child support or alimony • Proof of retirement or pension payments • Most recent property taxes • Investment and stock statements

Dependents in Household

(This includes spouse, children under 18 and all others claimed on your tax return)

Dependent Name (First, Middle and Last Name if different than patient)	**Age**	**Date of Birth**	**Social Security Number**

Employment

	Patient/ Responsible Party	Spouse
Employer Name:		
Current Gross Weekly, Monthly, or Yearly Income (Before Taxes)		

Other Income

	Patient / Responsible Party	Spouse
Social Security		
Retirement/Pension		
Unemployment / Workers Compensation/ Rental Income		
Stocks, Bonds, 401K, Dividend Interest		
Other		

Expenses

	Patient / Responsible Party	Spouse
Child Support		
Medical Expenses		
Pharmacy Expenses		

I understand, certify that the above information is true and accurate to the best of my knowledge. I understand that the information submitted is subject to verification. In the review process, a credit report may be requested to verify information provided in this application. I understand that falsification of information submitted may jeopardize my consideration for the program. Furthermore, to qualify for <u>this</u> program, I understand I must apply for any and all assistance that may be available to help pay this hospital bill prior to completing this application.

Signature _____ Date _____

Hospital Use Only

Patient Application Approved Yes No

If No, Reason Why _____

Hospital Representative Signature:_____ Date:_____