RE: Patient Financial Assistance

Dear Applicant:

Stonewall Jackson Memorial Hospital (SJMH) is dedicated to the belief that all citizens of our community have the right to essential, quality medical care. In some situations, medical care is necessary and neither the patient, nor the family, has the financial resources to pay for those necessary services. Our hospital has a financial assistance program in place to assist those individuals in this situation.

Attached is the application you will need to complete. **All sections must be completed and copies of the following documents must be returned with the application:**

- Most current Federal Income Tax return
- Tax receipts for all personal and real property
- Medicaid denial/approval, if applicable
- Current month bank statement for checking/savings accounts
- Most recent paycheck stub(s) for all persons in household
- All bills from SJMH Physician Offices and SJMH Home Health

Return with Application

Use a separate sheet of paper if there is any information that you wish us to consider in evaluating your application.

This information is necessary to determine your eligibility for financial assistance and will be kept confidential. Your application cannot be processed until all of the above information is provided to the Credit/Collections Department. It is in your best interest to complete and return this application to us if you feel you are unable to pay your bill. If you qualify, based on assets, debts, and income, your account may be written off **up to** 100%.

If you have any questions or need assistance completing your application, please contact our office at 304-517-1160. The office hours are Monday-Friday, 8:00 a.m. to 4:00 p.m.

Return to:

230 Hospital Plaza Weston, West Virginia 26452 • Phone 304-517-1160 • Fax 304-517-1415

- ☐ MHMC
- ☐ PMH
- ☐ SJMH
- ☐ Other:____________

FINANCIAL ASSISTANCE APPLICATION

Section A: Information Regarding the Applicant

Full Name	**DOB**	**SSN #:**
Mailing Address	**City**	**State**
Zip Code	**Telephone Number**	**Present Employer**
Hire Date	**Employer's Address**	**Position or Title**
Supervisor's Name	**Telephone Number**	**Present Gross Salary**
How Often Paid	**Other Income (Alimony, Child Support, etc.)**	**How Often Paid**
Source		

	YES	**NO**
Are you or your spouse a Mon Health Medical Center, Preston Memorial or Stonewall Jackson employee?		
Were you an active Medicaid recipient at the time of your service?		
If yes, please indicate Medicaid ID number:		
Were you an active recipient of Disability Assistance at the time of your service?		
Did or do you have health insurance (other than Medicaid)?		
If no insurance coverage, please explain:		
Are you homeless or have you received care from a homeless clinic?		
Do you participate in the Women's, Infants, and Children's Program (WIC)?		
Are you currently living in low/subsidized housing?		
Is the guardian responsible for the patient's bill?		
Patient is deceased with no known estate.		
Other		

Section B: Dependent Children Living with You

Please provide the following information for all the people in your immediate family who reside in your home. Family shall include the patient's spouse, and all children, natural or adoptive, under the age of (18).

First Name	Middle Initial	Last Name	Relationship to Patient	Date of Birth	Gross Income for last 12 months

Total persons in family:__________ **Total family income:_____________**
If you claim ($0) income, please explain your means of support, additional documentation will be required (i.e., friends, family)____
____

Section C: Assets - Please list all total income resources for:

	Current Balance
Savings Accounts with:	
Checking Accounts with:	
Stocks, CDs, and Dividends, etc. with:	

Section D: Expenses – Please list your monthly household expenses for:

	Total Owed		Total Owed
Mortgage or Rent		Utilities	
Prescriptions		Real Estate Taxes	
Food/Groceries		Medical Supplies	
Motor Vehicle Payment		Motor Vehicle Insurance	
Medical Bills		Charge and/or Credit Cards	
Other Expenses:		Other Expenses:	

I, ____, attest that the information provided in this form is true and correct to the best of my knowledge. I understand that proofs of my income and expenses will not be returned. I further understand that Mon Health Medical Center, Preston Memorial Hospital and Stonewall Jackson Hospital will verify my information and will ask for documentation to determine if I am eligible for financial assistance. I understand that if I provide false information, I may be denied financial assistance and may be responsible solely to pay my bill(s) in full. I also understand that I may not be eligible for future financial assistance.

_____Initial for release of Financial Information to Radiology Physicians
_____Initial for release of Financial Information to Anesthesiology Physicians
_____Initial for release of Financial Information to the following Physicians____

Patient or guarantor signature:____Date:______________________________

Print patient or guarantor signature:____Date:______________________________

Please mail completed application and supporting documentation in the envelope provided.

Sliding Fee Schedule - February 2025

Based on 200% of Federal Poverty Guidelines

Family Size	**Federal Poverty Guideline**	**100% Discount**
1	15,650	31,300
2	21,150	42,300
3	26,650	53,300
4	32,150	64,300
5	37,650	75,300
6	43,150	86,300
7	48,650	97,300
8	54,150	108,300

If family income falls below the amounts listed in the columns above, the account will be discounted by 100%.

Update February 2025