Grafton City Hospital

An Affiliate of MonHealth Vandalia Health

Financial Assistance
Application Form

To ensure that all members of our community have access to high quality care, Grafton City Hospital elects to provide financial assistance to individuals who are unable to pay for healthcare services. Individuals meeting the eligibility requirements, outlined in our Financial Assistance Policy, may be granted some level of financial assistance for medically necessary services performed by Grafton City Hospital providers.

Application Requirements Checklist:

The following is a general list of application requirements, as outlined in our *Financial Assistance Policy*. Please ensure that all areas are answered to the best of your ability and knowledge. Please contact our Financial Counseling Team for any specific questions or to speak to a helpful representative. Feel free to include and attach additional paper if there is any other information you wish us to consider.

Overall Patient Information

- Medicaid Denial Letter

Proof of Income

- Pay stubs from last 2 pay periods with YTD Income Totals and copy of Tax Return
- Validation of Assets
- Checking Accounts
- Savings Accounts
- CD's/Bonds
- Value of Home
- Make, Model and Approximate Value of Car(s), Recreational, etc.

Monthly Living Expenses

- Rent/Mortgage
- Gas
- Electric
- Telephone
- Water
- Auto Loan Payment
- Other, Food, Cable, Credit Cards
- Insurance Premiums Paid
- Life
- Health
- Home
- Auto
- Medical Bills/Prescription Drugs Paid Monthly
- Child Care

Double Check

- I have completed the application
- I have attached all necessary supporting documentation

Grafton City Hospital
An Affiliate of MonHealth

Financial Assistance
Application Form

Grafton City Hospital has elected to offer this opportunity to apply for financial assistance for your hospital medical bill(s). In order for us to review your information, this application (and all pages and supporting documents) must be completed in its entirety. The form, and all listed documentation, must be returned to the Hospital within 30 days. Failure to return all required documents may result in your application being denied for financial assistance.

Please provide the information requested to the following address:

Grafton City Hospital
Financial Counseling Office
1 Hospital Plaza
Grafton, WV 26354

Eligibility Requirements and Assistance Offered

Financial assistance may be offered to those patients who are uninsured or underinsured. Partial or full assistance may be granted based on each, individual patient's ability to pay.

Patients must fully comply with the application process, including submitting required documents, as well as completing the application process for all available sources of assistance, including Medicaid or Medical Assistance.

To qualify for Financial Assistance, the following conditions are evaluated:

1. Is the patient uninsured, or have limited insurance coverage?
2. Is the patient unable to access other programs that would not cover expenses (Medicaid, or the Health Insurance Exchange, for instance)?
3. What is the patient's family income in relation to the current Federal Poverty Guidelines?
4. Was the patient's service considered emergent or medically necessary?

Financial assistance is limited to medical care provided at Grafton City Hospital and by Grafton City Hospital medical personnel. The Hospital will uphold the confidentiality and dignity of each patient, and any information submitted for consideration will be treated as protected information.

Obtaining an Application

You may obtain copies of the Financial Assistance policy, Financial Assistance Application, and related policies by:

1. Visiting Grafton City Hospital and inquiring with the Hospital's Patient Access or Financial Counseling Staff in the front lobby and/or 4th floor.
2. Visiting the Grafton City Hospital website at www.graftonhospital.com
3. Call the Financial Counseling Office, directly, at 304-265-0400
4. Calling a member of the Hospital's Patient Access or Patient Account Representatives by calling 304-265-0400

Approval and Communication

Once all requested documents are received, the application will be reviewed. The Hospital's highly trained staff will work with each patient to ensure all documentation is completed. Within 30 days, an approval or denial letter will be mailed to each applicant along with any balance due (if still applicable). You will not be charged more than the amount generally billed. Balances that go unpaid will follow our Credit and Collections policy.

Exclusions

This policy only applies to services rendered at Grafton City Hospital and those services provided by Grafton City Hospital employed providers. This policy also excludes assistance for services that are cosmetic or elective, in nature, as outlined by the Hospital's policy.

Please stop by, or contact a representative at Grafton City Hospital
1 Hospital Plaza, Grafton, WV 26354 | Main Number: (304) 265-0400

Grafton City Hospital
An Affiliate of Mon Health

1 Hospital Plaza
Grafton WV 26354
Website: graftonhospital.com

Financial Assistance Application

Applicant Information:

Name: _____
Address: _____
_____
Phone: _____
DOB: _____ SSN: _____
Employer: _____
Employer Phone: _____

Co Applicant Information:

Name:_____
Addr: _____
_____
Phone: _____
DOB: _____ SSN:_____
Employer: _____
Employer Phone: _____

Dependents: Do you have custody of minor children under the age of 18? ☐ Yes ☐ No
Total Family Size? _____ List Dependents below:

Name _____ Age _____ Name _____ Age_____

Name _____ Age _____ Name _____ Age_____

Are you pregnant? ☐ Yes ☐ No
Have you recently been diagnosed with a major illness? ☐ Yes ☐ No

Monthly Earned Income:_____
Unearned Income:_____
Total Income:_____
Paid: ☐ Weekly ☐ Bi-Weekly ☐ Monthly
Hourly Rate: No Hours Worked:

Monthly Earned Income:_____
Unearned Income:_____
Total Income:_____
Paid: ☐ Weekly ☐ Bi-Weekly ☐ Monthly
Hourly Rate: No Hours Worked:

Assets:
Checking Account Balance:_____ Savings Account Balance:_____

Real Property Values: Home:_____ Automobiles:_____

Recreational Vehicles:_____ Stocks, Bonds, CD:_____

Monthly Expenses:
Mortgage/Rent:_____ Automobile Loan:_____

Utilities: Gas:_____ Insurance:_____
Water:_____ Child Care:_____
Electric:_____ Auto-Gas:_____
Telephone:_____ Medications:_____

Other Expenses:_____

Grafton City Hospital will make a determination of your eligibility for free or reduced services and will mail you a copy of the determination. This determination covers Grafton City Hospital services only. Financial Assistance allowances are left to the discretion of the individual physician or billing entity and are not governed by federal guidelines.

I authorize Grafton City Hospital to check my credit, verify assets and employment history. This authorization expressly permits all credit sources and employers to provide the hospital with any and all information requested.

_____ _____ _____ _____
Signature of Applicant Date Signature of Co-Applicant Date

Grafton City Hospital
1 Hospital Plaza
Grafton WV 26354

Financial Assistance Application

Designated Representative Authorization

I appoint Grafton City Hospital and its affiliates, to be my Designated Representative for the purpose of pursuing financial assistance for my medical expenses. This service will be provided at no cost to me.

My Designated Representative may:

Assist in the completion and processing of my application for applicable financial assistance with any agency or entity that offers such support. These programs may include local, state and federal funding sources such as County Human Services, Medicaid, Social Security, Disability Determination, and the Veterans Administration.

Obtain information about my assets, employment status and income to substantiate my application(s). Grafton City Hospital may sign authorization forms on my behalf to obtain this information from my bank, employer and/or government or financial entities.

Pursue the appeal process, up to and including legal proceedings, in the event my application(s) is denied, if appropriate.

Participate on my behalf and in my absence in any hearing or appeal. The rights, powers and authority of my Designated Representative commence on the date this authorization is signed and remain in full force and effect until the final conclusion of my application(s), or when revoked, in writing, by me or my legal representative.

I agree that any third party who receives a copy of this authorization may act under it.

I agree that I must revoke this Designated Representative Authorization in writing.

I agree that revocation of Grafton City Hospital as my Designated Representative is not effective until Grafton City Hospital or any third party is notified of the revocation in writing.

I agree that my refusal to sign this Designated Representative Authorization has no impact with respect to treatment, payment, enrollment or eligibility for benefits.

I agree that protected health information disclosed to Grafton City Hospital may be subject to re-release and is no longer protected by law.

I agree that I have had ample time to review all provisions of this Designated Representative Authorization.

I understand that additional authorization forms may need to be signed by me in order to process my application(s).

_____Applicant Initials _____ Date Initialed

I UNDERSTAND AND AGREE THAT ANY INFORMATION OBTAINED BY MY DESIGNATED REPRESENTATIVE MAY BE SHARED WITH MY HEALTHCARE PROVIDER.

I agree to all that is contained in this document:

_____ _____
Applicant Signature Date

Applicant Name: _____ DOB: _____

Address: _____ SSN: _____

_____

Phone: _____

_____ _____
Co-Applicant Signature Date

Co-Applicant Name: _____ DOB: _____

Address: _____ SSN: _____

_____

Phone: _____

This Privacy Notice describes how Grafton City Hospital and it's affiliates may use and disclose your protected health information. We may receive, create, maintain, use or disclose your protected health information consistent with the terms of documented in the Grafton City Hospital Notice of Privacy Practices.

If you have any concerns regarding your protected health information, or if you believe that your privacy rights have been violated, contact:

Privacy Officer
Grafton City Hospital
1 Hospital Plaza
Grafton WV 26354