MONONGAHELA VALLEY HOSPITAL

MVH CARE APPLICATION

Please attach proof of income from the past 30 days to this application. Please verify all income listed in Section One and Section Two. If you are unable to verify some or all of your income, please explain why on an attached sheet of paper. Applications will not be rejected for inability to verify income, provided that reasonable explanation for the inability is given.

- ☐ Pay stubs or letters from employers, listing wages before taxes.
- ☐ Award letters or bank statements showing deposits of Social Security, other disability, pension, worker's compensation, or unemployment compensation payments.
- ☐ Award letters, court documents, or bank statements showing deposits of child or spousal support payments.
- ☐ Documentation of other sources of income.
- ☐ If the household has no income, letters from persons who are assisting with daily living needs, explaining the help that the persons provide (e.g., grocery purchases or rent and utility payments).
- ☐ Health Savings Account (HSA) and other dedicated account statements.
- ☐ Checking and Savings account statements.
- ☐ Copy of Health Insurance Card(s), if applicable.

Form Revised 11-10

Please complete all questions in this section. Failure to complete this section could result in delays in evaluating eligibility for MVH Care.

Patient Information

Patient Name:_____ Date of Birth:_____

Street Address:_____

City/State/Zip:_____

Home Telephone:_____ Work Telephone:_____

Preferred calling time:_____

Current Health Insurance Company Name:_____

Policy Number:_____ Group Name/Number:_____

Household Members:

Please attach additional sheets of paper if household has more than eight members.

	Name	Relationship:	Age:
1.	_____	self	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

GUARANTOR/PATIENT NAME:

MVH ACCOUNT #: _____BALANCE: _____

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TOTAL BALANCE (ALL ACCOUNTS): _____

1. HOUSEHOLD INCOME (MONTHLY)

A. Wages

1. Total wages of patient/guarantor: _____
(Attach copy of paycheck stub)

1a. Employer Name: _____

1b. Employer Address: _____

2. Spouse's Name: _____

2a. Total Wages of Spouse: _____
(Attach copy of paycheck stub)

2b. Spouse's Employer Name: _____ 2c.

Employer Address: _____

II. OTHER INCOME

Pensions:_____ **Social Security:**_____

Other Disability:_____ **SSI:**_____

Cash Assistance:_____ **Unemployment Comp.:**_____

Worker's Comp.:_____ **Child Support:**_____

Spousal Support:_____ **Other (Please explain):**_____

Veteran's administration (VA) Benefits:_____**Annuities:**_____

Other Unearned Income (includes Trusts, Interest/Dividends, etc.):_____

_____

_____

III. TOTAL MONTHLY INCOME: $_____

IV. Household (Countable) Resources

Please list your available accounts and liquid assets for your household. A liquid asset is defined as cash or any type of negotiable asset that can be converted quickly and easily into cash. Do not include your home, household items, vehicles, IRAs, 401(k) accounts and other non-liquid assets.

Certificates of Deposit:_____ **Stocks or bonds:**_____

Trust Fund:_____ **Savings account:**_____

Checking Account:_____ **Savings Certificates:**_____

US Savings Bonds:_____ **Christmas or Vacation Club:**_____

Health Savings Account (HSA) funds:_____

Other (Please explain):_____

FOR HOSPITAL USE ONLY

_____

TOTAL NET SCHEDULED ASSETS $_____

Optional Questions

If you so choose, please answer the questions below to provide a better understanding of your ability to pay for medical care. Higher-than-average or otherwise unusual expenses may result in an adjustment of income downward. Lower-than-average expenses will not result in an adjustment of income upward.

Monthly Household Expenses

Mortgage/Rent:_____ Property Taxes:_____

Insurance:_____ Auto Loan:_____

Credit Cards (Total):_____ Water:_____

Gas:_____ Oil:_____

Electric:_____ Telephone:_____

Child Support:_____ Spousal Support:_____

Health Savings Account (HAS) Contributions:_____

Other (Please Explain):_____

Monthly Medical Expenses

Insurance Premiums:_____ Equipment:_____

Doctors' Visits:_____ Prescriptions:_____

Other (Please Explain):_____

ALL OF THE INFORMATION IS TRUE AND COMPLETE, AND MAY BE VERIFIED WITH THE LISTED INSTITUTIONS. I REQUEST EACH LISTED INSTITUTION TO RELEASE ALL OF MY PERSONAL ACCOUNT BALANCE INFORMATION TO MONONGAHELA VALLEY HOSPITAL IN ORDER TO VERIFY THE BALANCES/AMOUNTS LISTED.

_____ _____

Date **Signature of Applicant**