PO BOX 2353
Harrisburg, PA 17105-2353

UPMC
LIFE CHANGING MEDICINE

Patient name
Patient address
Patient address

Date:
Patient Name:
Medical Record #:

Dear :

Attached is the financial aid application as requested. To avoid processing delays with your application, please use the checklist to verify all information has been completed or attached as required.

- ☐ Complete the financial aid application, **sign and date**. Use N/A if applicable.
- ☐ Copy of last filed federal tax return with all schedules.
- ☐ If you do not file please provide a letter stating the reason, sign and date the letter

Proof of income is important. Applications without income information will be denied.

- ☐ Proof of monthly household income for all members of household:
  - Current and complete bank statement for checking, savings, business accounts showing all transactions for the last 30 days as of the date of this application
  - Current pay stubs for the last 30 days as of the date of this application

You must send us copies if you get any of these benefits:

- ☐ Notice received from Social Security Administration indicating current year monthly benefit
- ☐ Any pension payments that are received monthly
- ☐ Notice received from Bureau of Unemployment for weekly benefit
- ☐ Current denial or approval from Medical Assistance/Medicaid if you have applied
- ☐ Copy of denial or exemption letter from the Marketplace, HealthCare Exchange
- ☐ Copy of alimony or child support agreement, letter, check or bank statement with deposit
- ☐ If you have no income, the person who helps you with daily living expenses must write a letter describing the dollar amount of assistance they provide and the reason.

Your aid may be reduced or denied for refusal to enroll in a subsidized health plan due to the expanded Medicaid program in Pennsylvania.

Call us if you have questions at 717-231-8989 or 1-877-499-3899 (toll-free), option 3.

Sincerely,
Patient Financial Coordinator

UPMC
LIFE CHANGING MEDICINE

RETURN TO: Patient Financial Coordinator
UPMC in Central Pa
P.O. Box 2353
Harrisburg, PA 17105-2353

FINANCIAL AID APPLICATION

If you have any questions, please call Patient Financial Support Services 717-231-8989 or 1-877-499-3899.

Patient's Information

Last _____ First _____ MI _____ DOB _____

Address _____ City _____ State _____ Zip _____

SSN # _____ Phone # _____

Guarantor's Information (If Different Than Patient)

Last _____ First _____ MI _____ DOB _____

SSN # _____ Phone # _____ Relationship _____

Household Members:

Name	Relationship	DOB	UPMC in Central Pa Outstanding bills (Y/N)

Household Income (PROVIDE PHOTOCOPIES OF PROOF OF INCOME FOR LAST 30 DAYS)

		Employer/Occupation	Monthly Gross Amount
Wages:	Self		
	Spouse		
	Others		

Self Employment	
Pensions	
Social Security/SSI	
Unemployment or Workers Comp.	
Child/Spousal Support	
401 K Plans/Other Annuity Payments	
Veteran's Administration (VA Benefits)	
Public Assistance/Cash Assistance	
Income from Dividends, Interest, Rent	
TOTAL INCOME	

Expenses (NO PHOTOCOPIES NEEDED PLEASE ESTIMATE THE AVERAGE MONTHLY AMT)

	Creditor Name	Monthly Payment	Acct Balance
Mortgage/Rent			
Auto Loans/Leases			
Credit Cards			
Bank Loans			
Taxes Personal			
Real Estate			
Medical Bills			
Prescription Medicines			
Spousal Support			
Child Care/Support			
Phone (including cell)/	Cable/ Internet		
Electric			
Water			
Gas/Oil			
Sanitation			
Insurance Car			
Individual			
Home			
Health			
	Total Expenses		

Assets (PROVIDE PHOTOCOPIES OF FINANCIAL INSTITUTION STATEMENTS LAST 30 DAYS)

	Bank Name	Balance of Account ($)
Checking Account		
Savings Account		
Christmas/Vac. Club		
Certificate of Deposit		
Money Market Acct.		
Stocks/Bonds Health		
Savings Acct. Trust		
Fund/Annuities		
Other Assets		

I certify that the information contained in this application is true and complete.

Signature of Patient or Guarantor _____ Date: _____ Spouse _____ Date: _____