



Chan Soon-Shiong  
Medical Center  
at Windber

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**Charity Care at  
Chan Soon-Shiong  
Medical Center at Windber**  
Information Packet and Account Assistance Application

Revised: 12/31/07

Download the most recent version at [www.windbercare.org/charitycare](http://www.windbercare.org/charitycare)

**TABLE OF CONTENTS**

INTRODUCTION ..... 3  
SUMMARY OF ELIGIBILITY REQUIREMENTS ..... 4  
APPLICATION CHECKLIST ..... 5  
WHERE TO SEND YOUR APPLICATION ..... 6  
CALL US WITH YOUR QUESTIONS ..... 6  
ACCOUNT ASSISTANCE APPLICATION..... 7

## INTRODUCTION

Chan Soon-Shiong Medical Center at Windber is proud of its mission to provide quality care to all who need it, and to ensure the fulfillment of its mission to provide medically necessary care for all patients regardless of their ability to pay.

If you do not have health insurance and worry that you may not be able to pay for your care, we may be able to help. Chan Soon-Shiong Medical Center at Windber provides charity care and partial charity care to patients based on their income, assets, and needs. In addition, we may be able to assist you in obtaining government-funded healthcare or work with you to arrange a manageable payment plan.

Federal and state laws require all hospitals to seek payment for care provided. This means we could ultimately turn unpaid bills over to a collection agency, which could potentially affect your credit status. Therefore, it is important that you let us know if there may be a problem paying your bill.

For more information, please contact the Patient Accounting Customer Service Department at 814-467-3918. We will treat your questions and any information you provide us with confidentiality and courtesy.

Everything you need to apply for Charity Care is here in this packet of information. You can print off the necessary forms, complete them, and send with the other documentation that is required and explained in the application to the Patient Accounting Department.

## SUMMARY OF ELIGIBILITY REQUIREMENTS

- Patient must currently have outstanding medical bills, or anticipate having medically necessary services with no means to pay.
- Patient must apply for Medical Assistance if requested to do so, and cooperate fully and timely with the process to determine eligibility. Patient must provide the county welfare caseworker with all requested information.
- Patient must complete accurately a charity care application and provide all requested income and asset information.
- Patient must meet income guidelines as outlined in the Chan Soon-Shiong Medical Center at Windber Charity Care Policy\* to determine full or partial charity care.
- Patient must meet asset guidelines based on Chan Soon-Shiong Medical Center at Windber Charity Care Policy\*.

\*The Chan Soon-Shiong Medical Center at Windber Charity Care Policy is available from the Patient Accounting Customer Service Department. They can be reached by phone at 814-467-3918.

## APPLICATION CHECKLIST

Here is a checklist of the things you will need to complete the Account Assistance Application:

- Account Assistance Application Form** (included in this packet)

### Household information:

- The names, dates of birth, and social security numbers of family members

### Employment Information:

- Employer name, address, phone number

### Income information:

- Three months' pay stubs
- Previous year's tax return
- Self-employment profit and loss
- Other income information

### Information about assets such as:

- Checking and savings accounts
- IRA's and/or 401Ks
- CD's and money market accounts
- Mutual funds, Stocks, or Bonds
- Property owned

### Liabilities:

- Outstanding medical bills
- Costs of medication and health care supplies

### Other information:

- Medical Assistance denial, if applicable

## **WHERE TO SEND YOUR APPLICATION**

Please return this completed application and attachments to:

**Chan Soon-Shiong Medical Center at Windber**  
600 Somerset Avenue  
Windber, PA 15963  
Attn: Paula R.

## **CALL US WITH YOUR QUESTIONS**

If you have any questions about this application packet, please contact the Patient Accounting Department by phone at 814-467-3918.

## **ACCOUNT ASSISTANCE APPLICATION**

The information you provide in this form will enable Chan Soon-Shiong Medical Center at Windber to determine your ability to pay for the medical services that have been or will be provided to you. It will also be used to determine your eligibility for assistance with the payment of your account from CSSMCW. The information you provide will be kept confidential and will only be shared with CSSMCW employees, agents or business associates in connection with the determination of your ability to pay for the charges, a determination of your eligibility for account assistance and for the purpose of securing payment for the services provided.

**A. Patient and Household Information**

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
*(last, first, middle initial)*

SS#: \_\_\_\_\_ Day Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Night Phone: \_\_\_\_\_

Employed:  Yes  No Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Position: \_\_\_\_\_

Gross Monthly Wages: \$ \_\_\_\_\_ Other Monthly Income: \$ \_\_\_\_\_

*(Please provide copy of last 3 months pay stubs)* Source: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Separated  Widowed

Spouse/Guarantor Name: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Employed:  Yes  No Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Position: \_\_\_\_\_

Gross Monthly Wages: \$ \_\_\_\_\_ Other Monthly Income: \$ \_\_\_\_\_

*(Please provide copy of last 3 months pay stubs)* Source: \_\_\_\_\_

Total Household Monthly Income: \$ \_\_\_\_\_

*(“Income” includes wages, alimony, child or spousal support, social security, veterans or other disability payments, workers compensation, unemployment compensation, rental income, income from self-employment and pension or retirement income.) Please provide copies of any document showing the amount and frequency of payment of other income. Self-employed persons must show profit and loss for prior three months.*

Total Number of Dependents Including Self: \_\_\_\_\_

Do you own a business?  Yes  No

Business Name: \_\_\_\_\_

Business Address/City/State/Zip: \_\_\_\_\_





**B. Assets**

Monthly Mortgage: \$ \_\_\_\_\_

Monthly Rent: \$ \_\_\_\_\_

Assessed Value of Your Home: \$ \_\_\_\_\_

Amount Still Owed: \$ \_\_\_\_\_

Do you own or have interest in other real estate?  Yes  No

Property Address/City/State/Zip: \_\_\_\_\_

Co-owners: \_\_\_\_\_

Assessed Value: \$ \_\_\_\_\_ Amount of Mortgage Owed: \$ \_\_\_\_\_

*(if additional space is needed, please include on back of page)*

Make, Model, and Year of Vehicle(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Checking, Savings or Other Accounts:** Please attach supporting documentation (Including: IRA, 401k, Certificates of Deposit, Mutual Funds, and Money Market)

Type	Name of Bank/ Financial Institution	Account Number	Current Balance
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you own stocks, bonds, or any other investments?  Yes  No

Type: \_\_\_\_\_ Value: \$ \_\_\_\_\_

Type: \_\_\_\_\_ Value: \$ \_\_\_\_\_

Type: \_\_\_\_\_ Value: \$ \_\_\_\_\_

Type: \_\_\_\_\_ Value: \$ \_\_\_\_\_

### C. Liabilities

#### Monthly Expenses

Medication/Health Care Supplies \$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

Other Health Care Bills \$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

Other (Please List) \$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

\$ \_\_\_\_\_

### D. Tax Information

Please include the previous year's complete tax information, such as 1040 forms and any other supporting documentation.

### E. Other Information

Have you applied for Medical Assistance?  Yes  No      Date: \_\_\_\_\_  
(If yes, please provide copy of determination)

Did you have health insurance at the time of your treatment?  Yes  No  
If yes, please provide insurance company name and ID number:

Company Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**F. AUTHORIZATION AND VERIFICATION**

I, \_\_\_\_\_, hereby verify that the information provided for in this form is true and correct to the best of my knowledge, information and belief. I authorize Chan Soon-Shiong Medical Center at Windber to make any investigation necessary to verify my eligibility for financial assistance with my account including credit rating inquiry when necessary. I understand that falsification of this information may result in a denial of any request for assistance and my being solely responsible for the full charges for the services provided to me and may also affect my eligibility for future financial assistance. I further understand that my eligibility for financial assistance from the hospital may be re-evaluated for each subsequent hospital services. If the assistance is in the form of a payment arrangement, I understand that failure to make the required payment may result in termination of the payment arrangement and is my responsibility for the immediate payment of the account balance.

Date: \_\_\_\_\_

\_\_\_\_\_

*Patient or Patient Representative Signature*

\_\_\_\_\_

*Name of Representative*

\_\_\_\_\_

*Relationship to Patient*

**PLEASE RETURN THIS FORM AND THE DOCUMENTS REQUESTED TO THE FINANCIAL COUNSELOR IMMEDIATELY.**

**ANY CHANGES IN YOUR FINANCIAL SITUATION SHOULD BE REPORTED AS THEY MAY AFFECT YOUR ELIGIBILITY.**

**After your eligibility is determined you will be advised as to the type of assistance that is available to you.**

***For Office Use Only:***

**FACILITY:** \_\_\_\_\_

**APPLICATION APPROVAL DATE:** \_\_\_\_\_

## **G. SUBMITTING YOUR APPLICATION**

Please return this completed application and attachments to:

**Chan Soon-Shiong Medical Center at Windber**  
600 Somerset Avenue  
Windber, PA 15963  
Attn: Paula R.