INCOME VERIFICATION FORMS NEEDED FOR DETERMINING FINANCIAL ASSISTANCE

St. Mary's Medical Center will make medically necessary services available on an inpatient or outpatient basis to individuals who cannot afford to pay for such services as determined by its hospital Uncompensated Care Policy. The Medical Center will not discriminate based on race, color, sex, handicap, religion or national origin in determination of financial indigency. Financially indigent shall mean uninsured or underinsured patients who have no ability to pay due to their income levels.

Eligibility for financial assistance will be determined by comparing household family income and number in family against the Federal Poverty Guidelines. **ALL OF THE FOLLOWING MUST BE GIVEN TO A ST. MARY'S FINANCIAL COUNSELOR FOR YOU TO BE CONSIDERED FOR FINANCIAL ASSISTANCE.**

____ The last two pay stubs from the last 2 pay periods for yourself and anyone residing in the household over the age of 18. If you or your spouse are unemployed a certification of no employment must be completed.

_____ Bank Statement from the past **30 days** from your bank, this statement must show your direct deposits for Social Security, Employment, Child Support, etc.

____ Federal Income Tax Return from the previous year. If you do not file taxes, please initial _____.

____ Social Security determination form received in December, for you and spouse if one is listed.

____ Federal Income Tax Form Schedule C for self-employed individuals.

____ Child Support if it is received.

____ Letter from Supporter, if you live in a household and pay rent, utilities, etc., dated and signed with phone number to contact.

____ Unemployment Compensation Forms.

____ Denial Letter from Medicaid if you are self-pay and have no other insurance.

Married_____ Single_____ Divorced_____ Widowed_____

PLEASE NOTE: If the information requested is not complete, your application cannot be processed and will be mailed back to you.

When listing dependents, this means anyone under the age of 18 unless they are in high school and only if you are the official guardian of the listed dependent. Also, please provide proof if not biological parent.

The above forms need to be submitted to a St. Mary's Medical Center Financial Counselor along with a completed Financial Assistance Application. We will respond to you within 10 working days of the receipt of all required information whether your financial assistance has been approved or denied. If your application has been approved, financial assistance will be good for any medically necessary services that occur within 6 months after the application. If you have any questions, please do not hesitate to contact our Financial Counselors Jessie Downing, (304) 526-1539, Jessica.downing@st-marys.org or Toni Malcomb at (304) 399-7238, Toni.malcomb@st-marys.org Please return application to St. Mary's Medical Center, Financial Counselor, 2900 1st Ave Huntington, WV 25702.

By signing below, you are confirming that all the information provided is true.

Guarantor/Patient Signature: _____Date: _____

Patients Name: _____ Acct_____ MRN_____

ST. MARY'S MEDICAL CENTER FINANCIAL ASSISTANCE APPLICATION

Patient's Last Name	Patient's First Name	Middle Initial	Date of Application	Patient Account #	Patient's Date of Birth

Patient's Home Address	Patient's City	Patient's State	Patient's Zip Code

Social Security #	Home Phone #	Work Phone #	Name of Guarantor	Relationship to Patient

Guarantor's Address	Guarantor's City	Guarantor's State	Guarantor's Zip Code

Guarantor's Employer	Guarantor's Employer Address	Guarantor's Employer Phone #

Name of Dependent(s) Living With You	Income	Relationship	Age
1.			
2.			
3.			
4.			
5.			
6.			

Total Number of Qualifying Dependents: _____

Yearly Wage Calculation:

_____

_____

_____

Guarantor/Patient Signature: _____ Date: _____

***** FOR OFFICE USE ONLY *****

Financial Counselor Signature: _____

Approved By: _____ % Amount Approved: _____ Date: _____

To be considered for a Medication Credit with your Charity Application, please fill out attached paper and send back to:

St. Mary's Medical Center
Patient Accounts
Jessie Downing/Toni Malcomb
2900 First Avenue
Huntington, WV 25702

Medication List (Please include over the counter and vitamin medication cost as well).

Patient Name: _____ **Date of Birth:** _____

Pharmacy: _____ **Pharmacy Phone:** _____

Medication	Monthly Out-of-Pocket Cost
TOTAL COST MONTHLY	$

Patient Name: _____

If you are not working and cannot supply check stubs or Social Security documentation, please fill out this form.

Who is supporting you at this time? _____

Phone No. of the Supporter: _____

Address of Supporter: _____

Relationship to Supporter: _____

Signature of Supporter: _____

*By signing above, you are certifying that you support the above-named person because they have little or no income.

* * *

If you live in a shelter or rehab facility, please list the name of the facility and the facility number for verification purposes above.

Shelter Name: _____

Shelter Phone No.: _____

* * *

Have you applied for Medicaid? Yes _____ No _____

Are you in the process of filing for Social Security disability? Yes _____ No _____

I _____ certify that I have little, or no income and I am supported by another individual, facility, or residential facility. By signing you are certifying that the information on this form is true and will be shared with the program that is determining the outcome of your application.

Failure to complete this letter will result in denial of your application. We are required by law to submit this information if you are indicating that you have no income. Incomplete application will result in the return of this application to you.

CERTIFICATION OF NO INCOME

***Please complete all Sections Below**

I, the undersigned patient, hereby certify that I received no income from any source during the timeframe of _____/_____/_____ to _____/_____/_____. I understand that this certification shall be used to determine what amounts I should owe on my medical bills from St. Mary's Medical Center. I further understand that, if St. Mary's Medical Center later determines that I did receive income during the time listed above, I will be held responsible for paying those medical bills.

* * * * *

*Did you file income tax for the previous year? _____ Yes _____ No

*If you did NOT file taxes for the previous year, what was the last year that you did file income taxes? _____

* My last Employer was _____. Last month/year worked _____

* Are you receiving Unemployment Compensation currently?
_____Yes _____ No

* * * * *

By signing below, you are certifying that the information outlined above is true. Please have someone other than an immediate family member witness your signature:

Patient's Signature _____ Date _____

Patient's Name (please print) _____

Witness Signature _____ Date _____

***Please do not leave anything blank on this form. Incomplete paperwork will result in the application being denied as "Incomplete" and the entire application will be returned to you.**

2026 HHS Poverty Guidelines

Persons in Family Unit	FPG 100%	% of Charges Eligible for Uncompensated Care 80%	60%	40%	20%
1	$15,960	$19,152	$22,344	$25,536	$28,728
2	$21,640	$25,968	$30,296	$34,624	$38,952
3	$ 27,320	$32,784	$38,248	$43,712	$49,176
4	$33,000	$39,600	$46,200	$52,800	$59,400
5	$38,680	$46,416	$54,152	$61,888	$69,624
6	$44,360	$53,232	$62,104	$70,976	$79,848
7	$50,040	$60,048	$70,056	$80,064	$90,072
8	$55,720	$66,864	$78,008	$89,152	$100,296