

**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 abilities 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.**

\_\_\_\_ Two pay stubs from the last 3 months pay periods. If you are not employed or receive social security but you have listed a spouse, you must provide a signed letter stating that you and or your spouse receive no income.

\_\_\_\_\_ Bank Statement from the past 30 days from your bank or if you do not have a bank account a signed letter from yourself stating that you do not have an active account in your name. 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.

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 Melanie Kerstetter at (304) 399-7238, Melanie.Kerstetter@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 information provided is true.

Guarantor/Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Acct\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MRN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*MAK 03/20/25*

**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****1.** | **Income** | **Relationship Age** |
| **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/Melanie Kerstetter

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.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| A green and black sign  Description automatically generated**2025 HHS Poverty Guidelines**  |  |  |  |
|  |  |  |  |  |  |
| **Persons in** | **FPG** | **% of Charges Eligible for Uncompensated Care** |
| **Family Unit** | **100%** | **80%** | **60%** | **40%** | **20%** |
| 1 | $15,650 | $18,780 | $21,910 | $25,040 | $28,170 |
| 2 | $21,150 | $25,380 | $29,610 | 33,840 | $38,070 |
| 3 | $26,650 | $31,980 | $37,310 | $42,640 | $47,970 |
| 4 | $32,150 | $38,580 | $45,010 | $51,440 | $57,870 |
| 5 | $37,650 | $45,180 | $52,710 | $60,240 | $67,770 |
| 6 | $43,150 | $51,780 | $60,410 | $69,040 | $77,670 |
| 7 | $48,650 | $58,380 | $68,110 | $77,840 | $87,570 |
| 8 | $54,150 | $64,980 | $75,810 | $86,640 | $97,470 |
|   |   |   |   |   |   |
|   |