Webster MemorialHospital
DAVIS HEALTH SYSTEM

324 Miller Mountain Drive * P.O. Box 312 * Webster Springs, WV 26288

For Assistance in completing application, contact the Patient Advocate at 304-847-5682 extension 2071

FINANCIAL ASSISTANCE APPLICATION

Webster Memorial Hospital, Inc. (WMH) will grant financial assistance to qualified patients on the self-pay
portions of their accounts as long as resources are available to finance such care.

In order to receive financial assistance, application for such service must be made within **60 days** of discharge and the
application must meet the following eligibility requirements:

1. care rendered **must not** be for experimental, cosmetic, or elective reasons and must be medically appropriate;
2. the applicant's financial situation is consistent with the provision of charity care:
   - ♦ assets are those necessary for the patient's daily living
   - ♦ income does not exceed the amount needed to meet patient's daily living expenses; and
3. the applicant is not eligible for public assistance (Medicaid); or
4. there is no other source of payment for the patient's medical bill; for example, medical insurance coverage; and

ATTACHMENTS:
All applicants must attach the copies of the following. **Incomplete applications will be denied.**

1. Federal or State tax returns for last year if applicable.
2. Copy of most recent social security related income amount if applicable.
3. Pay stubs for three (3) months for all family unit members who are employed.
4. Proof of any other source of income.
5. Proof of paid property and personal taxes.
6. All bank statements for three (3) months.
7. Copy of denial letter from Medicaid.
8. Copy of Food Stamps for the past 12 months
9. Any other information deemed necessary by WMH:
   - ♦ proof of no income for family unit members as applicable
   - ♦ proof of monthly pharmacy expenses and other medical expenses
   - ♦ proof of expenses, assets, liabilities as described, if applicable
   - ♦ proof of 3 months of utility bills

WEBSTER MEMORIAL HOSPITAL, INC.
FINANCIAL APPLICATION

For which program(s) are you applying?
( ) Financial Assistance – Request for 100% of bill to be written off
( ) Sliding Fee – Discounts up to 90% off of bill

Patient Name: ______________________________________ Phone #: ___________

Social Security #: ________________________ Date of Birth: ____________________

Address (if PO Box include route number and/or road name):

____

____

Age: ____ Marital Status: _______ West Virginia Resident (Y/N): ______

Section 1 - HOUSEHOLD & EMPLOYMENT INFORMATION

List all persons living in household.

NAME	RELATIONSHIP/DATE OF BIRTH	INSURANCE

Current Employer: ___________________________________ Phone #: __________
Address: ____
Position Held: _________________________ Dates of employment: ______________

Last Employer: ______________________________________ Phone #: __________
Address: ____
Position Held: _________________________ Dates of employment: ______________

Spouses Employer: ___________________________________ Phone#: ___________
Address: ____
Position Held: _________________________ Dates of employment: ______________

Section 2 – MONTHLY HOUSEHOLD INCOME & EXPENSES

HOUSEHOLD MONTHLY INCOME (Attach Proof)	
Wages:	Food Stamps:
Tips:	Retirement:
Alimony/Child Support:	Unemployment:
Social Security:	AFDC:
Other (Specify):	Other (Specify):
TOTAL INCOME:	

HOUSEHOLD MONTHLY EXPENSES		
Description:	**Monthly Amount:**	**Total Liability (if applicable):**
House Rental/Payment:		
Food:		
Car Payment:		
Car Operating Expenses:		
Phone:		
Electric/Gas:		
Water/Sewer:		
Other Medical:		
Other (Specify):		
TOTAL EXPENSES:		

Section 3 - ASSETS

ASSETS
House/Land Value:
Car/Truck Value:
Name and Address Of Bank:
Savings Account Amount: $
Checking Account Amount: $
Stocks/Bonds/CDs:
Guns/Jewelry over $500.00:
Retirement Funds/Pensions:
Cash Value of Life Insurance:
Other Assets (Specify):
Other Assets (Specify):
Other Assets (Specify):
TOTAL ASSETS:

Net Income/Net Worth: To Be Completed by the Patient Counselor:	
Total Income	
Less Total Expenses	
Total Assets	
Less Total Liability Amount	
Net Worth	

Section 4 – APPLICANT OTHER THAN PATIENT
If applicant is deceased, please complete the following:

1. Date patient expired ________________________.
2. Is there a surviving spouse? (Y/N) _________. If yes, name and address of surviving spouse: ____
____
3. Is there an estate? (Y/N) ________________________
4. How was this verified? ________________________
5. Name of person making application. ________________________
6. Relationship to patient. ________________________

Section 5 – AUTHORIZATION AND CERTIFICATION

Applicant:
Witness:

Completed by:

____
Patient Advocate