



**FINANCIAL ASSISTANCE APPLICATION**

PATIENT NAME: \_\_\_\_\_

DATE OF SERVICE: \_\_\_\_\_

ACCOUNT NUMBER: \_\_\_\_\_

Listed below are the documents that are needed to complete your Financial Assistance Application. This application **MUST** be completed and returned within 30 days.

Please provide the following documents to verify income:

\_\_\_\_\_ 1040 TAX RETURN (MOST RECENTLY FILED) (FRONT PAGE OF FEDERAL INCOME TAX RETURN INCLUDES NUMBER OF DEPENDENTS CLAIMED)

\_\_\_\_\_ SOCIAL SECURITY BENEFITS FOR CURRENT YEAR (COPY OF BANK STATEMENT IF DIRECTLY DEPOSITED)

\_\_\_\_\_ UNEMPLOYMENT BENEFITS (COPY OF UEMPLOYMENT DETERMINATION NOTICE)

\_\_\_\_\_ PAYSTUB(S) LAST 30 DAYS

\_\_\_\_\_ PENSION (COPY OF BANK STATEMENT IF DIRECTLY DEPOSITED)

\_\_\_\_\_ DISABILITY/WORKERS COMPENSATION

\_\_\_\_\_ PROOF OF ANY OTHER SOURCES OF INCOME (ALIMONY, CHILD SUPPORT, RENTAL INCOME)

\_\_\_\_\_ MEDICAL ASSISTANCE DETERMINATION LETTER

\_\_\_\_\_ MOST RECENT CHECKING AND/OR SAVINGS ACCOUNT STATEMENT

\_\_\_\_\_ CERTIFICATE OF DEPOSIT (CD) STATEMENT

SIGNATURE \_\_\_\_\_

Please sign and return the form and documents as soon as possible to the appropriate address/email address below:

**Butler Memorial Hospital** (724-284-4460): Mail application to Butler Memorial Hospital, One Hospital Way, Butler, PA 16001, ATTN: Patient Financial Services or email to [PatientFinancialServices@butlerhealthsystem.org](mailto:PatientFinancialServices@butlerhealthsystem.org).

**Clarion Hospital** (814-393-6042 or 724-393-6048): Mail application to Clarion Hospital, One Hospital Drive, Clarion, PA 16214, ATTN: Financial Counselor or email to [ClarionFinancialCounselor@butlerhealthsystem.org](mailto:ClarionFinancialCounselor@butlerhealthsystem.org).

**Butler Medical Providers** (724-284-4022 or 724-284-7458): Mail application to Butler Medical Providers, PO Box 447, East Butler, PA 16029, ATTN: BMP Patient Accounts or email to [BMPPatientAccounts@butlerhealthsystem.org](mailto:BMPPatientAccounts@butlerhealthsystem.org).