FINANCIAL ASSISTANCE PROGRAM

Family Income Documentation – please submit one or more of the following:

_____ Copies of the 2 most recent pay stubs

Enter employment start date (mm/yyyy) _____

If pay stubs not available:

_____ Copies of the most recent tax return

_____ Copies of the most recent W-2 form and 1099 form

_____ Written verification from an employer, if paid in cash

_____ Copies of monthly benefits statement from Social Security

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Please provide copies of the following items:

_____ Warner Hospital & Health Services Determination of Eligibility for Financial Assistance, Application Form #712.

_____ Forms approving or denying assistance from the Department of Public Aid (You must apply for medical assistance if you meet one of the following criteria: children living in the home, you are permanently disabled, pregnant or age 65 or above. Initial and date if none apply.)

_____ _____
Initial Date

_____ Checking Account Statements (past 3 months)

_____ Savings Account Statement (past 3 months)

Please return requested information **WITHIN 90 DAYS FOLLOWING DATE OF DISCHARGE OR RECEIPT OF OUTPATIENT CARE OR MAY BE DENIED FOR UNTIMELY APPLICATION.**

Your cooperation with Warner Hospital & Family Services is extremely important in determining your eligibility for financial assistance.