601 Colliers Way Weirton, WV 26062-5091 ● 304-797-6042, option 3

# Weirton Medical CenterFinancial Assistance Information

It is the policy of WMC to provide financial assistance to uninsured patients who either demonstrate financial need or are deemed presumptively eligible for assistance based on established criteria

For your convenience, a WMC Financial Counselor will evaluate your financial needs and a determination will be made based on established criteria. As part of the program, you may be required to apply for Medical Assistance.

# Steps in the Application Process

1. First, explore if you are eligible for some type of insurance benefits that would cover your care (such as Medicaid, Worker’s Compensation, Liability Insurance, etc.)
2. If you are not eligible for other coverage, fill out the below Charity Care Application below. Make sure to gather supporting documents listed in Charity Care Checklist and include with application.
3. Applications are accepted in-person or via mail. If you are mailing in your application, please send it to:

**Weirton Medical Center**

**Attn: Financial Counselors**

**601 Colliers Way**

**Weirton, WV 26062**

1. A Weirton Medical Center Financial Counselor will then look at your income, assets, and family household size to determine the level of assistance that you qualify for.
2. We will get in touch with you to let you know if you are eligible for Weirton Medical Center Charity Care and/or if we need any further supporting documentation or information to process the application.
3. If you are ineligible for Weirton Medical Center Charity Care, we are able to set-up interest free payment plans or go over other options for payment.

# Financial Assistance Document Checklist

The following documents may be necessary to have when applying for Weirton Medical Center’s Charity Care program. Other documents may also be necessary once the application has been started. Please determine, from the following list, what applies to you to ensure that are fully prepared. The Financial Counselors will use the information to determine your income level and if you qualify.

Income includes:

* Wages and salaries before deductions
* Net income from self-employment (profit & loss sheet)
* Social security retirement income
* Unemployment compensation
* Worker’s compensation
* Misc: Disability, pensions, strike benefits, public assistance, alimony, child support, dividends, interest, rental income, gambling, and lottery winnings

󠄊 Most recent Tax Return and W2 Forms (Turbo Tax printout is acceptable. No hand written taxes)

󠄊 Most recent paystub (must show year-to-date)

󠄊 Unemployment Income

󠄊 Worker’s Compensation

󠄊 Alimony

󠄊 Proof of disability/Social Security (Current Last 1 Year Award Letter)

󠄊 Proof of Pension

󠄊 Proof of Child Support/Court DocumentsProof of food stamps/EBT (printout obtained at local DHHR for last 12 months)

󠄊 Proof of H.U.D

󠄊 Notarized letter from anyone assisting patient financially

󠄊 Proof of rental income/rental receipts

󠄊 Mortgage payment receipt

󠄊 󠄊 Copy of utility payments

󠄊 Proof of stocks, bonds, etc.

󠄊 Complete/current bank statement for 1 full month for checking, savings, etc. (Must have bank name letterhead on the statement or stamped by the bank)

󠄊 Identification/Driver’s license

󠄊 Proof of Medicaid Application/MarketPlace application

󠄊 Affordable Care Act Coverage

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Charity Care Application

|  |  |
| --- | --- |
| Date: | Referred By: |
| Patient Name:  |
| Medical Record No: | Account No: |
| Address:  |
| Social Security No: | Date of Birth: |
| Home Phone: | Cell Phone: |
| Marital Status (circle): Married Single Divorced Separated WidowedNumber of Dependents Claimed: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Employer: | Job Title: |
| Employer Address:  |
| Spouse Employer: | Spouse Job Title: |
| Spouse Employer Address:  |

Checking, Savings, or Other Accounts (IRA, 401K, Certificates of Deposit, Mutual Funds/Money Markets)

|  |  |  |  |
| --- | --- | --- | --- |
| Type | Name of Bank | Account Number | Current Balance |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

# Authorization and Verification

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby verify that the information provided for this form is true and correct to the best of my knowledge. I authorize Weirton Medical Center to make any investigation necessary to verify my eligibility for Charity Care with my account(s) including, but not limited to, credit rating inquiry to credit agencies. In the event there would be a change in income, address, employment information, change in insurance, or any other circumstance that could affect this charity care application, I am required to notify Weirton Medical Center within 30 days of the date of the change. I understand that falsification of this information may result in a denial of any assistance and my being solely responsible for the full charges for the services provided. I further understand that my eligibility for Charity Care may be re-evaluated for each hospital service. I hereby authorize Weirton Medical Center and its authorized representatives to act on my behalf in all matters related to my application for Medicaid or any applicable State and/or Federal programs without additional written authorization. I authorize all face to face interviews, telephone interviews, and any written communication that is necessary for the completion of my application. I do hereby authorize any bank or financial institution, government agency or department, hospital corporation or person to furnish any information concerning me or my affairs to Weirton Medical Center and/or any of its authorized representatives.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Use Only

Approved: Yes / No

Charity Care Period: Date:

Financial Counselor Signature: Date:

Supervisor / Director Signature: Date:

Card #: