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

Weirton Medical Center
Financial 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 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

4. 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.

5. 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.

6. 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 Counselor: _____

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

☐ Last three (3) months' pay stubs (must show year-to-date)

☐ Unemployment Income

☐ Worker's Compensation

☐ Alimony

☐ Proof of Social Security Disability and/or Retirement Income (Current Year Award Letter)

☐ Proof of Pension, IRA Distribution, 401k Retirement Income

☐ Proof of Child Support/Court Documents/Proof 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

☐ Proof of stocks, bonds, etc.

☐ Complete bank statements for all accounts including checking, savings,
certificates of deposit, etc. (3 months)

☐ Identification/Driver's license

☐ Proof of Medicaid Application, Marketplace Application, Affordable Care Act Coverage

Financial Counselor: _____

Financial Assistance Application Form

SECTION ONE: PATIENT INFORMATION
Print your full name, address (at the time you received medical service) and other information noted in this section.

Account Number(s)_____ Date(s) of Service_____

Patient Name: _____ _____ _____
LAST FIRST MIDDLE INITIAL

Address: _____ _____ _____ _____
NUMBER AND STREET CITY STATE COUNTY

State of Residence_____ Zip Code_____ Date of Birth: _____/_____/_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary Phone Number: (_____) _____ ☐ Home ☐ Mobile ☐ Work ☐ Other _____

Email Address: _____

Health Insurance at time of date of service: _____ ☐ No Insurance ☐ Medicare ☐ Medicaid ☐ Other _____

SECTION TWO: FAMILY INCOME
Provide income for yourself, your spouse and all family members, if applicable.

Income Source	Total for 3 Months Prior to Service	Total for 12 Months Prior to Service
Wages/Self Employment	$	$
Social Security	$	$
Pension/Dividends, 401K, Roth IRA, Interest, Rental Income	$	$
Unemployment, Workers' Compensation	$	$
Child Support (only if the patient is the intended recipient)	$	$
Other	$	$

SECTION THREE: FAMILY INFORMATION AND INCOME
List all family members in your household and their date of birth.

Please provide the following information for all the people in your immediate family who live in your home. Family is defined as the patient, the patient's spouse and all of the patient's children under 18 (natural or adoptive) who live in the patient's home. If the patient is under 18, the family shall include the patient, the patient's natural or adoptive parent(s), and the parent(s) children under 18 (natural or adoptive) who live in the patient's home.

Name of family members, including patient Date of Birth Relationship to Patient

1 Patient: _____

2. _____

3. _____

4. _____

5. _____

By signing below, I certify that everything I have stated on this application and any of the attachments is true.

Responsible party signature: X_____ **Date:**_____

Return your completed application to: **ATTN: Financial Counselors** - 601 Colliers Way - Weirton, WV 26062 (304) 797-6042 Option 3