GOODALL-WITCHER Healthcare

Goodall-Witcher Hospital
Goodall-Witcher Clinic in Clifton
Goodall-Witcher Clinic in Whitney
Goodall-Witcher Home Health Agency
Goodall-Witcher Nursing Facility
Goodall-Witcher Fitness & Wellness Center

Dear Applicant,

Attached you will find the Goodall-Witcher Healthcare Financial Assistance Application. Completion of this application will enable us to consider your medical expenses at Goodall-Witcher for financial assistance. IN MOST CASES, OFFICE VISITS AND PREVENTIVE CARE WILL NOT BE COVERED

We understand your desire for privacy. Accordingly, the information you include with your application will be treated as confidential information. It will be available only to the Financial Assistance Program personnel on a need to know basis.

The application and documentation **must be returned within 15 days** to Goodall-Witcher Healthcare Eligibility Office. A self-addressed, stamped envelope is provided for your convenience. If you have difficulty filling out the application or have questions regarding the program, please call 254-675-8322 (ext. 7305). Your cooperation is appreciated. The list of documentation that is needed is listed below:

- ◯ Proof of Income (Recent and Consecutive)
  - Employed: Two (2) months' paycheck stubs or letter from employer
  - Self-Employed: Three (3) month ledger (gross income)
- ◯ IRS Form W-2/1099
- ◯ 2021 Full Tax Return

  ***If you cannot provide a tax return, you must provide a written letter explaining why you are unable to submit a tax return.**
- ◯ If not working, a letter of support from individual/company providing the support.
- ◯ Recent Supplemental Security Income (SSI)/Social Security Disability Income (SSDI)/Retirement Award Letter
- ◯ Last 3 month's detailed bank statement for all checking/savings accounts (*ATM receipts will not be accepted*)
- ◯ Photo ID
- ◯ Food Stamp Award Letter (if applicable)
- ◯ Other Resources (Child Support, 401K, IRA, Stocks, Bonds, etc.)

Thank you for choosing Goodall-Witcher for your healthcare needs.

Sincerely,

Eligibility Specialist
Goodall-Witcher Healthcare

Application: Financial Assistance/Charity Care

Responsibility of Bill (please print)

Last Name _____ First Name_____ Middle _____

Street Address _____ City _____ State _____ Zip_____

Date of Birth _____ Social Security # _____Phone number _____

1. Is this application for future or past service? Future ___ Past___ Date of Services _____

If future what are your specific needs? _____

2. Has anyone in your household applied for the County Indigent Health Care Program, Children's Health (CHIPS), or Medicaid?

Yes_____ No _____ Who _____

When _____ What is the status: Pending _____ Denied _____ Reason _____

3. Is anyone in your household pregnant? Yes _____ No _____

4. Has anyone in your household served in the military? Yes _____ No _____ Who? _____

5. Have you ever filed a workers' Compensation or motor vehicle accident claim? Yes _____ No_____ Date _____

6. Is anyone in your household eligible for Social Security benefits? Yes ____ No _____ Who? _____

7. Is anyone in your household covered by health insurance or a health savings account (HAS)? Yes ☐ No ☐

Who? _____

8. Does anyone else claim you on their income tax return? Yes ☐ No _____ Who? _____

List all dependents, including your spouse:

Name	Age	Relationship/ applying for benefits

MONTHLY INCOME

Do you have an income? Yes_____ No _____ Amount $_____

Does your spouse have an income? Yes _____ No ☐ Amount $_____

If yes, you must provide recent pay stubs, receipts if self-employed, proof of public assistance payments, Social Security, unemployment, workers' compensation, child support, alimony, etc. **DOCUMENTATION IS REQUIRED.**

For office use only:
Date turned in: _____ Approved Date: _____ Denial Date: _____ Reason: _____

ASSETS

NOTE: Married person should include spouse's financial information.

Cash on hand/or in banks. $_____

(Checking $_____ Savings $_____ Credit Union $_____)

Automobiles, boats, motor homes, etc…… $_____

Real estate (Property) $_____ Mobile Home? If yes, what year: _____ $_____

All other assets not specified above: please include description and value below

Total Assets…… $ _____

Household Expenses

Monthly Rent Payment $_____ or Mortgage Payment $_____ Mortgage Loan Balance $_____

Property Tax amount not included in payment amount above $_____ Value of home $_____

Do you own property other than the primary residence Yes_____ No_____ If yes, value $_____

Monthly loan payment $_____ Paid to _____ For _____

Medicare Part D deducted from Social Security Check Yes _____ No_____ Amount $_____

Utilities $_____ Insurance $_____ Living (gas, food, clothes) $_____ Other_____ $_____

Alimony/Child Support $_____ Health Insurance $_____ Child Care $_____ Other _____$_____

Assignment of Rights

By signing below I authorize the request of my credit report and/or tax return. I understand that a tax return is needed to process the application and that more information may be requested before my eligibility can be determined. You may attach the documents and submit this application.

By signing below, I certify that all information I have submitted is true. I understand that any incorrect, incomplete or false information that I provide or someone else provides for me could cancel my application for financial assistance.

All adult household members who sign below authorize the release of my any medical, financial or employment information which relates directly to their health care or to their financial assistance eligibility. This information may be released to any health care provider from whom household members have sought healthcare services or financial assistance. All information provided will remain confidential under the provisions of HIPPA federal guidelines. Elective procedures may not be considered for assistance.

I agree that I will repay the full assistance award if I receive payment of any kind for the medical service covered by this application, for example insurance payments, government program payments, award from a lawsuit or any other payment.

If I receive Financial Assistance, I agree to inform Goodall-Witcher Healthcare of any changes which could impact eligibility, including changes to family size, income, and health insurance coverage. I understand that if my/our medical situation changes so that I/we might be eligible for a public assistance program, I will need to apply to that program and provide proof of application.

_____ _____

Applicant Signature Date Co-Applicant Signature Date