Polara Health

GUIDING YOUR WAY TO WELLNESS SINCE 1966

PATIENT FINANCIAL ASSISTANCE PROGRAM

Polara Health recognizes that certain patients may require financial assistance in paying for healthcare services. The Patient Financial Assistance Program has been designed by the hospital in response to the needs of these patients.

Attached is the Patient Financial Assistance Application for you to complete and return to us by the date noted below.* The information requested on the form will assist us in determining if you qualify for assistance. Please fill out the form as completely as possible and return with copies of applicable items below.

- ☐ Paycheck stubs for last three (3) months, or W-2 for previous year
- ☐ Social Security award letter
- ☐ Unemployment check stubs for last three (3) months
- ☐ Proof of pension
- ☐ Current IRS tax return
- ☐ Bank and/or credit union statements for last three (3) months
- ☐ Investment statements for last three (3) months
- ☐ Mortgage statements from last three (3) months, and annual property tax statements
- ☐ Self-employment business records
- ☐ In absence of income, a letter of support from individual(s) providing for the basic living needs of Patient

Other required items to show your relationship to other household members, entitlement to Social Security, and legal residency are:

- ☐ Birth or baptismal certificate or adoption papers for minor age children
- ☐ Marriage License
- ☐ Social Security Cards
- ☐ Current Driver's License
- ☐ Other document proving legal residency

Please select all applicable service programs

CSU ☐ Windhaven Inpatient ☐ Outpatient Services ☐

An incomplete application will be denied until it is fully completed. Upon review our billing office staff will contact you with the next steps

Polara Health Billing Office:
Application

* Due date**:** ________________________

Polara Health

PATIENT FINANCIAL ASSISTANCE APPLICATION

PATIENT FIRST NAME | MI | LAST NAME | DOB

GUARANTOR'S FIRST NAME	MI	LAST NAME	SEX	DOB	SOCIAL SECURITY #
ADDRESS OR PO BOX		CITY	STATE	ZIP	PHONE
SPOUSE'S FIRST NAME	MI	LAST NAME	SEX	DOB	SOCIAL SECURITY #
ADDRESS OR PO BOX		CITY	STATE	ZIP	PHONE

# IN HOUSEHOLD	PATIENT LIVES IN HOUSEHOLD Yes No	ACCOUNT NUMBERS
# OF CHILDREN UNDER 18 IN THE HOUSEHOLD	# OF DEPENDENT CHILDREN OVER 18	
# OF DEPENDENT CHILDREN OVER 18 THAT ARE FULL-TIME STUDENTS	# OF DEPENDENT CHILDREN THAT ARE DISABLED	
REAL ESTATE (SELECT ALL THAT APPLY) Own Rent	OTHER REAL ASSETS (PROPERTY, COLLECTIBLES, ETC.)	

MONTHLY INCOME SOURCES	SELF	SPOUSE	CHILDREN	TOTAL
Employment				
Social Security				
Industrial Comp				
Unemployment				
Pension/Retirement/Annuities				
ADC, GA, Food Stamps				
Other (rental income, child support, spousal, etc.)				
TOTAL GROSS INCOME				

EMPLOYER OF RESPONSIBLE PARTY				
ADDRESS	CITY	STATE	ZIP	PHONE
POSITION		MONTHLY INCOME $		START DATE

CHECKING Yes No	TOTAL AMOUNT $	BANK NAME
SAVINGS Yes No	TOTAL AMOUNT $	BANK NAME

I CERTIFY THAT THE INFORMATION GIVEN HEREON IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT DELIBERATE FALSIFICATION CAN LEAD TO DENIAL OF CONSIDERATION. I HEREBY AUTHORIZE THE HOSPITAL TO MAKE ANY NECESSARY INQUIRIES TO VERIFY THE INFORMATION PROVIDED AND TO OBTAIN ANY ADDITIONAL INFORMATION REQUIRED BY FACILITY.

APPLICANT SIGNATURE	DATE
CO-APPLICANT SIGNATURE	WITNESS SIGNATURE

- RELATIONSHIP OF HOUSEHOLD MEMBERS: Birth or baptismal certificate or adoption papers for minor-age children, marriage license, divorce decree or legal separation documentation.
- SOCIAL SECURITY CARDS
- PROOF OF RESIDENCY: Current Driver's License, other documents proving residency.
- ASSETS: Bank and credit union statements for the last three (3) months, stocks, bonds, securities, time certificates.
- INCOME FOR ALL HOUSEHOLD MEMBERS: Checks or check stubs/employer's statement listing gross wages, self-employment business records, income award letters/grant or education benefits letter, other documents showing income. *Income Period __ _ to _________*
- BANK STATEMENTS FOR LAST THREE (3) MONTHS
- PREVIOUS YEAR TAX RETURN