Main Line Health®
Well ahead.®

Schedule B

MAIN LINE HEALTH CHARITY CARE AND FINANCIAL ASSISTANCE FORM
ATTESTATION OF NO INSURANCE

FACILITY: _____PATIENT NUMBER: _____

LAST NAME:_____ FIRST NAME:_____M.I._____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

SSN# LAST FOUR DIGITS: _____ DATE OF SERVICE: _____

I hereby certify that I am currently do not have the ability to pay for the hospital treatment and or other services including but not limited to Laboratory, Radiology, etc on the date stated above.

☐ **Initials:_____**

I understand that by signing this document, I am applying for Financial Assistance.

☐ **Initials:_____**

If any information I have given proves to be untrue, I understand that the hospital or other entity of Main Line Health, may re-evaluate my financial status and I may become liable for charges.

☐ **Initials:_____**

Last Date Employed:_____ Family Unit Size:_____ Family Annual Income:_____

I certify the above information is true and complete. I understand that willful falsification of information contained in this application will result in denial of Financial Assistance.

_____
Patient Signature

_____
Printed Name

_____
Date

If you have questions, please contact the MLH Business Office at: 484-337-1970 or request to speak to a representative in the MLH Financial Counseling Office at each hospital.

DISCLAIMER

Main Line Health reserves the right to request such information as pay stubs, income tax returns, bank statements, social security, and/or other liquid financial information deemed appropriate to determine qualification for assistance.