Internal use only
Facility Patient Number

Schedule C

Main Line Health Financial Assistance Application

Patient Name____

Patient Date of Birth____

Address:____
Number and Street *City* *State* *ZIP* *Country*

SSN# (Last Four Digits): __________________ Date(s) of Service: _________________________

I hereby certify that I 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.

I understand that by signing this document, I am applying for Charity Care or Financial Assistance. I will promptly provide the information necessary to process my application. Furthermore, I will apply for any assistance (Medicaid, Medicare, Insurance, etc.), that may be available to me for payment of my hospital charges. I will provide information and take action reasonably necessary to obtain such assistance and will assign or pay to the hospital, the amount recovered from the hospital charges.

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

Last Date of Employment: ____

Employer: ____
Name *Address*

Family Size (Required):____

Estimated Annual Income (Required): ____

Estimated Last 3 Months Income (Required): ____

Please Include Verification of Income Information to Include

- W-2 Forms
- Previous Year Income Tax Forms
- Last 3 Months of Paystubs

I certify that the above information is true and accurate to the best of my knowledge

Patient Signature: ___________________________________ Date: _________________________

Please Mail Completed Application To
Main Line Health
3803 West Chester Pike, Suite 250
Newtown Square, PA 19073

Applications may also be Faxed to 484-227-9005

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.