Main Line Health®
Well ahead.®

Schedule C

MAIN LINE HEALTH CHARITY CARE AND FINANCIAL ASSISTANCE APPLICATION

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.

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 EMPLOYED: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

FA MILY SIZE: _____

ANNUAL INCOME: _____

LAST 3 MONTHS INCOME: _____

PLEASE INCLUDE VERIFICATION OF INCOME INFORMATION TO INCLUDE W2 FORMS, 2016-2017 INCOME TAX FORMS OR YOUR LAST 3 MONTHS OF PAYSTUBS FOR 2017-2018.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE: _____ DATE: _____

PLEASE MAIL INFORMATION TO:
MAIN LINE HEALTH, 3803 West Chester Pike, Suite 250, Newtown Square, PA 19073

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.