Warren General Financial Assistance Program
(Charity Care Program)

Thank you for inquiring about the Warren General Hospital Financial Assistance Program.

The following documentation will be required for financial assistance consideration:

- Proof of income (for all members of the household)
- Proof of application to obtain coverage through government supported insurance exchange products (if uninsured)
- Local county medical assistance denial form
    - To contact the Warren County Assistance Office:
        - Phone: 1-800-403-4043
        - Online: www.compass.state.pa.us
        - In person: 210 North Dr. Suite A in North Warren on the State Hospital property

The required documentation assists with the eligibility and potential determination of discount percentages awarded for health care services. Please complete, sign, date, and return the application forms with all required documentation.

The application must be returned within 30 days.

Don't hesitate to contact me with any questions or concerns!

Thank you,

Whitney V. Morrison

Whitney V. Morrison
Financial Counselor
Warren General Hospital
Two Crescent Park West
Warren, PA 16365
814.723.4973 Ext. 1325
wmorrison@wgh.org

Warren General Hospital reserves the right to require additional income verification and re-application at your local county assistance office for future healthcare services.

Financial Assistance Application
(Charity Care Application)

Warren General Hospital offers financial assistance to those with limited income, limited resources, the uninsured, and those ineligible for local county medical assistance and/or government supported insurance exchange products.

Affidavit and Confidential Request for Reduced Cost Hospital Care

Demographics:

Patient Name: _____

Head of Household: _____

Address: _____

_____

Phone Number: (_____) _____-_____

List below the complete names and birthdates of all members of the household:

_____

_____

_____

_____

Income:

List the *gross income* of every member of the household:

Patient's Income: _____/month

Spouse's Income: _____/month

Parent's Income: _____/month

Roommate's Income: _____/month

Other's Income: _____/month

Any other source of income: _____/month

TOTAL gross income for most recent month: _____/month

Health Insurance:

Do you have health insurance? _____

If yes, what is the name of your health insurance? _____

Why are you requesting reduced hospital costs? _____

_____

REQUIRED DOCUMENTATION: (Please attach the following documentation for your application to be processed)

1. Proof of income for one month (for all members of the household)
2. Proof of application to obtain government supported insurance exchange product (if uninsured)
3. Local County Medical Assistance denial form

I certify that the information provided on this application is accurate and true. I authorize Warren General Hospital Financial Services Department to verify the above information in the course of review for reduced hospital cost for care.

Applicant Signature: _____ Date: _____

This application must be completed and returned within 30 days