Summersville Regional Medical Center
400 Fairview Heights Road • Summersville, WV, 26651 • 304-872-8418

FINANCIAL ASSISTANCE APPLICATION FORM

Patient Name:_____

Address: _____

_____

Social Security Number: _____ Telephone #: _____

A Medicaid denial letter is required in order to process this application.

Are you covered by any health insurance including Medicare or Medicaid? Yes _____ No _____
If yes, please attach a copy of your insurance card that was effective during your hospital service, to this application.

Gross Monthly Income for Patient and Legally Responsible Relatives

$_____ Wages: copy of last 3 pay stubs

$_____ Social Security: copy of award letter or bank statement showing direct deposit

$_____ Unemployment or Workers Compensation: proof of amounts received

$_____ Alimony/Child Support proof of amounts received

$_____ Other – please describe

_____

$_____ Total Monthly Income $ _____ Total Annual Income
**Income verification must accompany this application.

Family Members in Household

Name	Birth Date	Age	Relationship
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____

Total number of Persons in Household: _____

Authorization and Agreement
By my signature below, I certify that everything I have stated on this application and on my attachments is correct.
Signature _____ Date _____

Please submit the completed forms and all requested documentation to:

Summersville Regional Medical Center
Attn: Wendy Willis, Financial Consultant
400 Fairview Heights Road
Summersville, WV 26651

Please contact the Financial Consultant at (304) 872-8418 if you have any questions or require any assistance.