Mail Completed Application To:
The Guthrie Clinic
Attn: Financial Assistance
One Guthrie Square, Sayre PA 18840
570-887-2051

Financial Assistance Application

Patient's Name: _____ Date of Birth: _____

Street Address: _____ City,State,Zip: _____

County: _____ # of Months/Years_____ Telephone: _____

Health Insurance Company: _____

Employer (self):_____ (spouse): _____

List total number of dependents in your household as defined by the I.R.S.

Dependent Information: (attach extra sheet as necessary)		(SSN if available)
Name:	**DOB:**	**SSN:**
Name:	**DOB:**	**SSN:**
Name:	**DOB:**	**SSN:**
Name:	**DOB:**	**SSN:**

***Status of Applications:* (optional)**

Medicaid: ☐ have not applied ☐ pending ☐ denied (attach copy)

Healthcare Marketplace: ☐ have not applied ☐ pending ☐ denied (attach copy)

Monthly Income: (please include all income from all individuals in your household)

Monthly GROSS Household Income: $ _____ Attach pay stubs for the most recent 1-month period.

Monthly Interest & Dividends: $_____ Provide copies of most recent statements.

Monthly Pension & Social Security: $ _____ Provide copies of most recent award letters.

Monthly Rental/Business Income: $ _____ Provide 3 months income and expenses.

In Kind Income $_____ See definition on application instructions.

Other supporting documents: (please include with your application)

Bank statement (most recent detailed).

Heath Savings Account (HSA) Statement showing current balance (if applicable).

Receipts (medical expenses paid including pharmacy costs) **optional.**

4029 Tax Exemption Form (if applicable)

I affirm by my signature below that the information contained in this application is true to the best of my knowledge. I agree to provide additional information as requested in order to determine eligibility. I agree to inform The Guthrie Clinic within 30 days of any changes in my needs, address, or a change in my income. I agree to allow The Guthrie Clinic to use the information on this application to determine my financial assistance eligibility at all participating providers.

Applicant's Signature:_____Date: _____

Printed Name of Person Completing Form: _____
(If other than patient)

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

Name of Applicant
The name of the person who is responsible for paying the patient's bill.

Date of Birth of Applicant:
The applicant's date of birth

Address:
The applicant's address refers to the residence of all family members included in the application. All family members covered by this application must reside at this address. This address cannot be a business address or an empty lot. For non-emergent care services, a patient must be a resident for six (6) months or more in The Guthrie Clinic Service area, which consists of the following counties: Bradford, Sullivan, Susquehanna, Tioga, and Wyoming in Pennsylvania and Broome, Chemung, Cortland, Schuyler, Steuben, Tioga, and Tompkins in New York.

County:
County where Applicant resides.

Number of Months in this County:
Number of months that Applicant has resided in above county.

Telephone Number:
Telephone number where applicant can be reached.

Health Insurance Information:
Provide a copy of your current insurance card. Patients who have access to other medical care (e.g. primary and secondary insurance coverage) must utilize and exhaust their benefits before qualifying for the financial assistance program; however, the program is available to assist patients with coinsurance, deductibles, or co-payments (excluding co-insurance, deductibles, or copayments required by Medicaid or other need-based programs).

Employer:
Place of employment for patient and spouse if applicable.

Dependent Information:
Family members must receive at least fifty (50) percent of their support from the responsible party to be included in the family size calculation. Proof of support includes the family members being listed on the prior year's tax return as a dependent, canceled checks, or copies of many orders for support expenses.

Status of Applications: (Medicaid or Healthcare Marketplace)
Applicants must provide proof of Medicaid application from his/her home state for income levels less than 150% of the Federal Poverty Level. Mark the "Denied" box if the family members clearly are not eligible for Medicaid and continue completing the application. Applicants must provide proof they have applied to the Healthcare Marketplace if they are uninsured or did not qualify for Medicaid.

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

Monthly Income:
Monthly Gross household income:
Income will consist of the annualized current gross earnings based on the pay stub or employer letter. If circumstances have changed that require the use of the lower figure (i.e., the applicant took a lower paying job), these circumstances must be documented in the file.

Monthly Interest and Dividends:
Include statements from savings accounts, stocks, bonds, annuities, and similar securities.

Monthly Pension and Social Security:
Payments from retirement plans and/or pensions. Retirement plans and pensions come in many forms. Some examples are: Tax Sheltered Annuities, Deferred Compensation, Individual Retirement Accounts (IRSs), 401(k) plans. Social Security award letter showing the current income received.

Monthly Rental/Business Income:
3 months income/expenses and coinciding bank statements from rental properties (including boarding and lodging).
3 months income/expenses and coinciding bank statements from business income (most recent federal tax form/schedules).

In-Kind Income:
In-Kind Income is the value of goods and services received as a substitute for monetary payment. These goods and services are usually room (shelter) and board (food).

Other Supporting Documents: (please include with your application)
Bank statement (most recent detailed for 1 full month)
Health Savings Account (HAS) Statement showing current balance (if applicable)
Receipts (medical expenses paid including pharmacy costs) **optional.**
4029 Tax Exemption Form (if applicable)