Highland-Clarksburg Hospital
3 Hospital Plaza
Clarksburg, WV 26301
304-969-3105

Financial Assistance Application

If you currently have Medicare, Medicaid, or Private Insurance, it is not necessary to complete this application

Name: _____
First Last Middle

Patients Name: _____

Address: _____
Street City State Zip code

Social Security Number: _____-_____-_____ Phone: _____

Employer Name: _____

Employer Address: _____

Is Patient covered under a health insurance plan? Yes No

If yes, Insurance Name: _____ Group Number: _____

Policy Number: _____ Effective Date: _____

Patient's Monthly Gross Income: $_____

Other Monthly Family Income: $_____

Total Family Income: $_____

Family Size: _____ Admission Date: _____

YOU MUST SEND PROOF OF INCOME

I certify that the above information is true and accurate to the best of my knowledge. Further, I will apply for any assistance (Medicare, Medicaid, Insurance, etc.) that may be available to me for payment that I received. I will take any action responsibly necessary to obtain such assistance and will assign or pay the provider of service the amount recovered. If any information that I have given proves to be false, I understand that the Hospital may reevaluate my financial status and take whatever action becomes appropriate.

_____ _____
Signature (Patient/Guardian/Responsible Party) Date

Do Not Write Below This Line – For Office Use Only

Income Verified? Yes _____ No _____ Type of Verification: _____

Verified by: _____ Approved _____ Denied _____

Discount Percentage: _____