

Dear Patient,

Enclosed is an application for Uncompensated / Charity Care, which will be used to determine your payment responsibility for the medical services you receive from GSPP Rehabilitation.

Determinations are based on a family's current income and number of dependents. In addition, expenses and available financial resources are taken into consideration.

Please complete the enclosed application and return to:

Patrick Sebastian, VP of Patient Financial Services
GSPP Rehabilitation
850 South 5th Street
Allentown, PA 18103

In order to determine your eligibility for charity care, please provide copies of at least **two** of the following documents:

- Latest federal tax return (if not available state return)
- Most recent pay stub
- Pension check
- Bank statement
- Social Security letter
- Disability letter
- Unemployment letter

Approval for GSPP Rehabilitation's Uncompensated / Charity Care is also contingent upon all other funding sources being pursued for payment of your medical services. This includes applying for Medicaid (Medical Assistance) which can be done through your County's Assistance Office. After you apply for Medical Assistance benefits, please send a copy of their eligibility determination letter to our office.

If you have any questions, please do not hesitate to contact us at 877-807-2840. The application and proof of income can be faxed to 610-778-9272.

Sincerely,
Patrick Sebastian
Vice President of Patient Financial Services

GSPP REHABILITATION
850 South 5th Street
Allentown, PA 18103
FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME		PATIENT NUMBER	BIRTH DATE
MARITAL STATUS		SPOUSE NAME	
SOCIAL SECURITY#	TELEPHONE#	EMPLOYER NAME & ADDRESS	
GUARANTOR ADDRESS			
CITY		STATE	ZIP CODE

SECTION A

ADDITIONAL FAMILY MEMBERS	
NAME/RELATIONSHIP	AGE
MONTHLY INCOME:	SOURCE OF INCOME:
\$	(GUARANTOR)
\$ TOTAL	

SECTION B

MONTHLY EXPENSES	
RENT	\$
MORTGAGE	\$
OTHER HOUSING	\$
FOOD	\$
ELECTRIC	\$
GAS	\$
HEAT	\$
TELEPHONE	\$
CABLE	\$
GARBAGE	\$
OTHER	\$
OTHER	\$
OTHER	\$
OTHER	\$
TOTAL	\$

SECTION C

OTHER EXPENSES	
CLOTHING	\$
TRANSPORTATION	\$
(Bus, train, etc.)	\$
SCHOOL	\$
DONATIONS	\$
TOTAL	\$

SECTION D

INSURANCE	
CAR	\$
HOUSING	\$
MEDICAL	\$
LIFE	\$
TOTAL	\$

SECTION E

CREDIT CARDS			
NAME	CURRENT BALANCE	CREDIT LINE	MONTHLY PAYMENT
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$

SECTION F

OTHER ASSETS	
Own Home: yes no	Other Real Estate
Approximate Value of Home:	Approximate Value of Other Real Estate
Mortgage Balance Owed:	

SECTION G

LOANS			
NAME OF INSTITUTION	ORIGINAL BALANCE	CURRENT BALANCE	MONTHLY PAYMENT
	\$	\$	\$
	\$	\$	\$
		TOTAL	\$

SECTION H

MEDICAL BILLS			
NAME OF MEDICAL ESTABLISHMENT			MONTHLY PAYMENT
			\$
			\$
			\$
			TOTAL
			\$

EMAIL ADDRESS: _____

SIGNATURE _____

DATE _____

OFFICE USE ONLY			
SUMMARY			
SAVINGS ACCOUNT (INSTITUTION/ACCOUNT#)	SECTION A	\$	
_____ \$ _____	SECTION B	\$	
	SECTION C	\$	
CHECKING ACCOUNT (INSTITUTION/ACCOUNT#)	SECTION D	\$	
_____ \$ _____	SECTION E	\$	
	SECTION F	\$	
MUTUAL FUNDS (INSTITUTION/ACCOUNT#)	SECTION G	\$	
_____ \$ _____	SECTION H	\$	
MONEY MARKET FUNDS (INSTITUTION/ACCOUNT#)	SECTION B TO H	\$	
_____ \$ _____			
INSURANCE POLICY (INSTITUTION/ACCOUNT#)	TOTAL DISPOSABLE INCOME		
_____ \$ _____	(B TO H MINUS A)	\$	

PROPOSAL		
	APPROVAL	DATE
INSTALLMENT CONTRACT	_____	_____
	PATIENT ACCESS / PATIENT ACCOUNTS STAFF	
MEDICAL ASSISTANCE APPLICATION	_____	_____
	DIRECTOR OF PATIENT FINANCIAL SERVICES	
CHARITY CARE	_____	_____
	SR. VICE PRESIDENT OF FINANCE/CFO	
	_____	_____
	PRESIDENT	

Fax# 610-778-9272