Dear Patient,

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

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

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

- Copy of your latest federal tax return (if not available state reason)
- Copy of most recent pay check stub
- Pension check
- Bank statement
- Social Security letter
- Disability letter
- Unemployment letter

The more information you provide will help us determine your eligibility.

Please send the application and proof of income to:

Jennifer Smith, Patient Financial Services
Good Shepherd Rehabilitation Hospital
Good Shepherd Plaza
850 South Fifth Street
Allentown, PA 18103

Approval for Good Shepherd'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, and forwarding a copy of their determination of your eligibility to us.

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,

Jennifer Smith
Patient Financial Services

Rev 12/18

GOOD SHEPHERD
850 South 5th Street
Allentown, PA 18103

FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME			PATIENT NUMBER	BIRTH DATE
GUARANTOR ADDRESS				
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	$

SUMMARY

SAVINGS ACCOUNT (INSTITUTION/ACCOUNT#)	$	SECTION A	$
		SECTION B	$
CHECKING ACCOUNT (INSTITUTION/ACCOUNT#)	$	SECTION C	$
		SECTION D	$
MUTUAL FUNDS (INSTITUTION/ACCOUNT#)	$	SECTION E	$
		SECTION F	$
		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	

SIGNATURE______________________________ DATE______________

Fax# 610-778-9272