GOOD SHEPHERD
PENN PARTNERS

Dear Patient,

Enclosed is an application for financial assistance, which will be used to determine your payment responsibility for the medical services you receive from Good Shepherd Penn Partners.

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:

John J. Sipko, Director of Patient Financial Services
Good Shepherd Penn Partners
Good Shepherd Plaza
850 South Fifth Street
Allentown, PA 18103

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

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

Approval for Good Shepherd Penn Partners' financial assistance 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,
John J. Sipko
Director of Patient Financial Services

CORFIN-0243 Rev: 04 15 16

GOOD SHEPHERD PENN PARTNERS
850 South 5th Street
Allentown, PA 18103

FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME		PATIENT NUMBER	BIRTH DATE
PATIENT 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#)
$

CHECKING ACCOUNT (INSTITUTION/ACCOUNT#)
$

MUTUAL FUNDS (INSTITUTION/ACCOUNT#)
$

MONEY MARKET FUNDS (INSTITUTION/ACCOUNT#)
$

INSURANCE POLICY (INSTITUTION/ACCOUNT#)
$

SECTION A	$
SECTION B	$
SECTION C	$
SECTION D	$
SECTION E	$
SECTION F	$
SECTION G	$
SECTION H	$
SECTION B TO H	$
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