Application Checklist

Your application must include this checklist as well as copies of all corresponding documentation.

1. **If you have cumulative outstanding patient balances due to Beebe Healthcare greater than $300.00.** If not please contact Patient Financial Services for acceptable payment arrangements 302 645-3546.

2. If you have no income:

□ Please have the person who provides your support complete the attached No Income Support letter explaining that they support you and include your signature.

3. If you have been denied Medical Assistance:

□ If you have been denied Medical Assistance through the State, please send us a copy of your 'Letter of Denial.' ***We cannot finalize your application without this letter***.

Documentation required: (see Application for detail requirements)

□ Pay stubs or required income documents
□ Tax return from most recent year (mandatory requirement)
□ Certification or Self Attestation of ineligibility or exemption from Insurance Market Place Mandate per the Affordable Care Act (**for applications after 2/1/15**)
□ Investment Statements
□ Bank Statements from two most recent months (**disposable Assets not to exceed $7,500.00 per household)**
□ Written statements from employer attesting to income
□ Proof of residency verified by Delaware driver's license and current utility bills

Did you complete and sign the Financial Assistance Application? _____

Are you eligible for the following:
Healthcare Connection Program (formerly CHAP) ***Date of Eligibility:*** _____
Screening for Life ***Date of Eligibility****:* _____
Other: _____
If yes, please provide documentation/ID which supports eligibility.

Patient Understanding:

I understand that the documentation requested will not be returned to me.

I understand that the information provided by me will be used to determine financial assistance and financial responsibility for my services at Beebe Healthcare.

I affirm that the information provided is true and complete. I authorize Beebe Healthcare to verify any information given. I understand that this information is subject to review by federal and/ or state enforcement agencies and others as may be required.

I understand to cooperate with the application process for State Medical Assistance if requested to do so by Beebe Healthcare, before I will receive financial assistance through Beebe Healthcare.

I understand that I will be financially liable for any services not covered through financial assistance.

I understand that upon receipt of a financial assistance approval letter, my financial assistance coverage will only be valid for up to one year from the date of approval.

I understand that if I do not qualify for financial assistance, account balances will remain in billing follow up status until I establish a monthly payment plan based upon balance thresholds established by Beebe Healthcare.

I understand that if any information I have provided is determined to be false, it may result in reversal of my financial assistance approval and I will be liable for all charges.

I grant permission for Beebe Healthcare to verify any of the information I have provided.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Spouse Date

Rev 07/17, 10/17