PENNSYLVANIA PSYCHIATRIC INSTITUTE
A Collaboration of Penn State Hershey & PinnacleHealth

FINANCIAL APPLICATION

This financial application needs to be completed for possible assistance with your bill(s) through our Financial Aid Program.

The following **must** be provided in order to review your application for possible assistance:

- Print the next two pages (financial application), fill out the information and sign it
- Proof of monthly household income:
  - 2 months of complete current bank statements
  - 4 current pay stubs for which you worked this year
- Notice of current Medical Assistance denial or approval (if applicable)
- Copy of notice received from Social Security Administration indicating monthly benefit *
- Copy of any pension payments that are received monthly *
- Copy of notice received from Bureau of Unemployment for weekly benefit.

* Required for those who are receiving benefits.

If self-employed then please include a copy of the Federal Income Tax return and Schedule C etc.

Please call our Business Office at 717-782-4783 if you have any questions or concerns regarding this application.

It is important to include the proof of income with your completed application otherwise, we will not be able to make a determination.

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RETURN TO:
Pennsylvania Psychiatric Hospital
Attention Business Office
P.O. Box 1855
Harrisburg, PA 17105-1855

FINANCIAL AID APPLICATION

Patient information

Last ______ First ______ MI ______

Street ______

City ______ State ______ Zip ______

Social Security # ______ Birthdate ______

Guarantor's Information (If Different Than Patient)

Last ______ First ______ MI ______

Social Security # ______ Birthdate ______

Relationship ______ Phone ______

Household Members:

Name	Relationship	Age	Sex

Household Income (PROVIDE PHOTOCOPIES OF STATEMENTS)

		Employer/Occupation	Monthly Gross Amount	Tax Deductions
Wages:	Self			
	Spouse			
	Others			
Self Employment				
Pensions				
Social Security/SSI				
Unemployment Compensation				
Child/Spousal Support				
401 K Plans/ Other Annuity Payments				
Veteran's Administration (VA) Benefits				
Public Assistance				
Income from Dividends, Interest, Rent				

TOTAL INCOME ______

Expenses

	Creditor Name	Monthly Payment	Acct Balance
Mortgage/Rent			
Auto Loans/Leases			
Credit Cards			
Bank Loans			
Taxes -personal			
real estate			
Medical Bills			
Prescription Medicines			
Spousal Support			
Child Care/Support			
Phone			
Electric			
Water			
Gas/Oil			
Sanitation			
Insurance car			
individual			
home			
health			
TOTAL EXPENSES			

Assets (PROVIDE COPY OF FINANCIAL INSTITUTION STATEMENTS)

	Bank Name	Balance of Account
Checking Account		
Savings Account		
Christmas/Vaca. Club		
Certificate of Deposit		
Money Market Acct.		
Stocks/Bonds		
Health Savings Acct.		
Trust Fund		
Other		

I certify that the information contained in this application is true and complete. I understand that willful falsification of information contained in this application will result in denial of charity care.

Signature of Patient /Guarantor or Guarantor ______________ DATE: ______________ Spouse ______________