Good Shepherd Rehabilitation

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 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.

Please complete the enclosed application and return to:

Jeremy Pijut, Director of Patient Financial Services
Good Shepherd Rehabilitation Hospital
Good Shepherd Plaza
850 South Fifth 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 reason)
- Most recent pay stub
- Pension check
- Bank statement
- Social Security letter
- Disability letter
- Unemployment letter

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. 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,
Jeremy Pijut
Director of Patient Financial Services

GOOD SHEPHERD
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#)
_____ $_____

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	

Fax# 610-778-9272