FINANCIAL ASSISTANCE POLICY – PLAIN LANGUAGE SUMMARY

Chambersburg and Waynesboro Hospital’s Financial Assistance Program, also referred to as Summit Care, exists to provide discounted emergent or medically necessary services to eligible patients.

**Eligible Services** are emergent or medically necessary healthcare services provided and billed by Summit hospitals. Some exclusions apply such as cosmetic procedures, non-emergent care that is sought out of network, or non-emergent services sought without regard to preauthorization requirements.

**Eligible Patients** are patients living in our community receiving eligible services as well as patients visiting our community who develop a need for emergent services. Patients must submit a complete financial assistance application, including required financial information, and be determined eligible by our Patient Accounting Department.

**How to Apply**

- Summit Care applications may be obtained as follows:
  - At Hospital Registration
  - From a Hospital Financial Counselor
  - At Hospital Emergency Room
  - Download from [www.summithealth.org/SummitCareApplication](http://www.summithealth.org/SummitCareApplication)
  - On your Billing Statement
  - By calling or visiting Patient Accounting Department:
    - Chambersburg Hospital
    - Waynesboro Hospital
    - 760 E Washington St
    - 501 E Main St
    - Chambersburg, PA 17268
    - Waynesboro, PA 17268
    - (717) 267-7129
    - (717) 765-3406

- Complete the application, gather requested financial information, and mail or bring your application to the Patient Accounting Office.

- If you need help completing your Summit Care application or have questions about the application, contact us so that one of our Patient Accounting staff members can assist you.

**Determination of Eligibility** is based on household size, income, and assets. Eligible persons are approved for financial assistance using a sliding scale when their family income is at or below 300% of the Federal Government’s Federal Poverty Guidelines (FPG).

- Family income at 0% to 200% of FPG - 100% financial assistance, patient pays $0.00
- Family income at 201% to 300% of FPG - 60% financial assistance, patient pays 40%

Summit Health is committed to charging no more than the average of those amounts that are generally billed to patients in our communities who are eligible for financial assistance. **Note:** Other criteria besides FPG are considered before extending the maximum discount, such as availability of cash or other liquid assets that may be converted easily to cash. Incomplete applications are not considered but applicants are notified and given an opportunity to furnish the missing information. Click [here](#) to view the full policy.
Financial Assistance Application for Chambersburg and Waynesboro Hospitals

Patient Name ____________________________________ Date of Birth: __________________

Home Address: _____________________________________________________________________________________

Phone Number: Home_________________________ Cell _____________________________ Best Time to Call?______

Household Members – (include only household dependents)

Name:        Relationship:          Date of Birth:        Social Security#:  

1. ____________________________________________ Self    ____________    _______________  
2. ____________________________________________    _____________    ____________    _______________  
3. ____________________________________________    _____________    ____________    _______________  
4. ____________________________________________    _____________    ____________    _______________  
5. ____________________________________________ _____________ _   ____________   _______________  

Monthly Gross Household Income Received:

Wages/Salaries (before taxes): __________________________    Pensions/Annuities: _____________________________  
Social Security: ______________________________________   Other Disability: ________________________________  
SSI/SSDI: _________________________________________    Cash Assistance: ________________________________  
Unemployment Compensation: _________________________    Workers Comp Compensation: ____________________  
Child Support: ______________________________________    Spousal Support: _______________________________  
Veteran’s Administration (VA) benefits: ___________________   Interest/Dividends: _____________________________  
Other Income: ______________________________________

Household Resources:

Checking Account(s): ________________________________     Savings, including Health Savings:_________________  
Christmas/Vacation Club: _____________________________    Stocks or Bonds: ________________________________  
Certificates of deposit: ________________________________    Money market accounts: _________________________  
Trust Funds: _______________________________________     US Savings Bonds: ______________________________

For your application to be processed, the following information must be returned along with this form:

• Checking and Savings account statements showing detailed activity from the previous month (individual and business). Statements must show financial institution name and customer account name and number.
• Federal Tax Return including all schedules, if taxes were filed.
• Pay stubs or letter from employer listing wages before taxes for previous 30 days from date of service.
• Proof of all other monthly gross household income received during the year.

Have you applied for Medical Assistance in the past 90 days?  Yes / No    If Yes, please attach determination notice.
Are you a member of a recognized health care sharing ministry?  Yes / No

Do we have your permission to share information contained in this application with other health care providers for them to determine financial assistance eligibility for their services?  Yes / No

I certify that the information provided on this application is true and complete and may be checked for accuracy. I understand that willful falsification and/or omission of information contained in this application will result in denial of financial assistance.

Requestor’s Signature: ___________________________________________   Date: ____________________________

If you have any questions, please call us for help: Chambersburg (717) 267-7129 Waynesboro (717) 765-3406

For Office Use Only ____________________________

Approved Date: _____________________   Discount %: ____________   Expiration Date: ________________________

Denied Date: _______________________   Reason for Denial: _____ Over Income ____ All documentation not received

Income: ___________________________   Processor: ____________________________   Date: __________________