



**Financial Assistance Program Application (Page 2)**

**\*Financial Assistance Is Not Health Insurance\***

Did LVHN provide care for injuries suffered in an accident caused by someone else?      Yes      No

If yes, describe below the circumstances of that accident. If you intend to make a claim against the person responsible for causing your injuries, or if you have already recovered any amount on account of such a claim, please identify any attorney you have retained to represent you in connection with that claim.

Date of Accident: \_\_\_\_\_  
 Nature of Accident: \_\_\_\_\_  
 Responsible Party: \_\_\_\_\_  
 Name and Phone Number of Attorney: \_\_\_\_\_

Monthly Household Income: Give monthly income for yourself and other household members. Also attach copies of your Federal Tax Return and other proof of income documents (see documentation checklist).

	Self	Spouse		Self	Spouse
Wages/Self-Employment			Unemployment		
Social Security			Workers Compensation		
Pension or Retirement Income			Alimony and Child Support		
Dividends and Interest			Other Income		
Rents and Royalties			<b>Total Monthly Family Income</b>		
			<b>Adjusted Gross Income</b>		

I certify that the above information is true and complete to the best of my knowledge.  
 I agree to apply for any assistance (Medicaid, Medicare, insurance) which may be available for payment of my LVHN account, and I will take any action reasonably necessary to obtain such assistance.

I understand that this application is made so that LVHN can determine my eligibility for Financial Assistance. If any information I have given proves to be false, I understand that LVHN will re-evaluate my financial status and qualification for Financial Assistance.

I authorize any bank, loan institution, insurance company, employer, or any creditor whatsoever of the undersigned to release any information requested by LVHN pertaining to any and all financial matters involving or relating to the undersigned.

I understand if I am approved for Financial Assistance and make a claim to recover damages from the third party causing the injuries, for which I received care at LVHN, or my own un/underinsurance, I am required to notify LVHN Patient Financial Services of that claim. I further understand that under those circumstances my Financial Assistance approval will be reclassified and placed in a pending status until the claim is resolved and it is determined how much of my recovery should be paid to LVHN.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ (Must be Power of Attorney or Parent or Legal Guardian of Minor Child- must show proof)

Do you give us permission to speak to someone else regarding your FAP application and related information?      Yes      No

If yes, who can we speak to? \_\_\_\_\_

**Please detach this form and upload to MyLVHN, Fax 484-884-8527 or forward it to:**

**Lehigh Valley Health Network**  
 ATTN: Patient Access, Financial Counselor,  
 2100 Mack Blvd, 3<sup>rd</sup> Floor  
 PO BOX 1866  
 Allentown PA 18105-1866

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