Tower Health at Home
Advancing Health. Transforming Lives.

PO Box 16052, Reading, PA 19612-6052
610-378-0481

APPLICATION FOR PATIENT FINANCIAL ASSISTANCE

Name: _____ Last 4 digits of Social Security #: _____ Date of Birth: _____

Current Address: _____
NUMBER & STREET CITY STATE ZIP

Home Telephone: _____ Cell Phone: _____

Previous Address if you have lived at
Current Address less than 2 years: _____
NUMBER & STREET CITY STATE ZIP

Do you rent or own your Home? ¨ Own ¨ Rent

Are you and/or any immediate family member residing in your household currently employed? ¨ Yes ¨ No
If YES, list the name of the person employed and his/her employer. Please remember to include yourself.

Name	Employer
Name	Employer
Name	Employer

If YES, is medical insurance available to you through any of these employers? ¨ Yes ¨ No

Are you covered under any other person's medical insurance? ¨ Yes ¨ No

If you do not work, how long have you been unemployed? _____

Please list names of people who live in your house, their relationship, and dates of birth

Name	Relationship	Date of Birth
Name	Relationship	Date of Birth
Name	Relationship	Date of Birth

Please attach the following for each household member. If unable to supply, please indicate the reason:

1. 1 Month of Pay Stubs:
2. Unemployment Compensation Check Stubs:
3. Income Tax return (Signed & Most Recent Year) including W-2 Withholding Statement:
4. DPA/MA Denial/Rejection: (web link for MA application: www.compass.state.pa.us)
5. Disbursement letter from Social Security Office for annual income verification.

Patient's Gross Annual Income:	$ _____
Other Family Income:	+$ _____
Total Family Income:	$ _____

I acknowledge that the information provided is true and correct. I authorize Tower Health at Home to verify any information contained in this document for the sole purpose of assessing financial need.

I understand that if my financial situation or availability of resources changes, I am required to notify Tower Health at Home of the change for the purpose of being reassessed for this program.

_____ _____
Signature of Patient Date