

Income Verification: As a condition to receiving Financial Assistance, you must attach copies of the following items for each household member providing income.

Latest Federal Income Tax return

Pay stubs for the 3 most recent months or a benefit statement for the current year (i.e. social security, unemployment compensation, etc.).

Family Size (list all family members in your household)

Name

Relationship

Age

Total Family Members (including applicant) _____

Mail your application to: Allied Services
Patient Finance Department
UFA Program
100 Executive Park
Clarks Summit, PA 18411

For assistance call:
877-727-3422
570-348-1372

I certify that the above information is true and accurate to the best of my knowledge. Further I will apply for any assistance (Medical Assistance, Medicare, Insurance, etc.) which may be available for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. I further understand that the information which I submit concerning my annual family income and family size is subject to verification by Allied Services. I also understand that if any information I have given is determined to be false, or if I fail to apply for other third-party assistance, such a determination will result in a denial of providing services as uncompensated care and I will be liable for the charges of the services provided.

Date of Request

Applicant's/Guardian Signature