UHC3 Application Instructions

1. Complete the Applicant Information completely. Note: only adult applicants should complete the application.

2. Complete Dependent Information for all persons living in your household who are your dependents (including your spouse); that is, all those who depend upon you for support. Be sure to include Social Security Number and Date of Birth for all members.

3. Complete Income Information for all sources of income for all members of your household. Attach copies of proof of income such as tax returns, pay stubs, bank statements, etc. Also attach any outstanding hospital bills for the Applicant and any dependents.

4. Sign the Release of Information section. Both the Applicant and spouse should sign this section.

5. Return the completed form to Financial Care Services located on the Main Floor of the Hospital to the left of the Garden Café or send it to Uniontown Hospital, 500 West Berkeley Street, Uniontown, PA 15401.

6. A representative will review your application and follow-up with you within ten (10) business days from receipt of the completed application. If you have not been contacted within this period, please contact us at (724) 430-1833.

7. Affordable Care Act application will need to be submitted with UHC3 application during enrollment period.

Uniontown Hospital Mission

Making a healthy difference in the lives that we touch.

Revenue Cycle Objective

Making a healthy difference beyond the numbers.

We Are ALL Here For You

UNIONTOWN HOSPITAL
FINANCIAL CARE SERVICES
500 West Berkeley Street
Uniontown, PA 15401
(Located on the Main Floor
to the left of the Garden Café)

(724) 430-1833
Uniontownhospital.com

Office Hours:
Monday through Friday 7:30 AM to 4:00 PM

3142-07 6/19

Financial Care Services

Uniontown Hospital

Community Charity Care Application

UHC3

UNIONTOWN HOSPITAL
We Will Make A Healthy Difference In The Lives We Touch

Uniontown Hospital
Community Charity Care Application

Applicant Information: All information provided by the applicant will be considered and treated as confidential. Furthermore, this information will be used solely for the purpose of determining eligibility for charity care through the UHC3.

Name of Applicant (Adult):	
Address:	Date of Application:
	Social Security Number:
	Date of Birth:
City, State, Zip:	Email Address:
Phone Number:	Cell Phone Number:

Dependent Information: List spouse and all dependents.

Name	Relationship	Social Security Number	Date of Birth

Income Information: List all combined sources of income, before taxes, of all members of the household. Attach verification for all sources to this application. Attach all outstanding Uniontown Hospital bills that may be related to this application.

☐ I have applied for ACA Affordable Care Act Insurance. (Proof is required.) ☐ I have healthcare coverage through my employer.

Income Source	Monthly Amount	Annual Amount
Wages		
Self Employment		
Social Security		
Public Assistance		
Pension		
Unemployment		
Child Support/Alimony		
Other		
Total of All Sources		

If no income is listed, please contact a representative at (724) 430-1833 to complete the processing of this application.

Release Information:
To the best of my knowledge, information, and belief, the information I have provided to Uniontown Hospital in support of this Charity Care Application is true and correct. I acknowledge that by signing here I authorize Uniontown Hospital to verify the financial information that I have provided and to obtain any necessary credit report for purposes of determining eligibility for charity care through the Uniontown Hospital Community Charity Care.

Signature of Applicant: _____ Date: _____

Signature of Spouse: _____ Date: _____