

P.O. Box 1259 * State College, PA 16804-1259 *814.234.6171 * www.mountnittany.org Mount Nittany Medical Center / Mount Nittany Physician Group

Financial Assistance Application

Please complete all of the information below and attach required documentation in order for us to assist you in your application process

HEAD OF HOUSEHOLD INFORMATION					
Head of Household Name:					
Head of Household Address:					
Head of Household Phone Nu	ımber:				
FINANCIAI	ASSISTANCE APPLI	CATION IS FOR TH	IE FOLLOWING ACC	COUNTS	
PATIENT NAME	DOS	ACCOUNT #	BALAN	BALANCE	
			TOTA	ıL	
If more space is needed to list	additional accounts please use	the back of this form.	1011		
PLEASE COMPI	LETE 1, 2 & 5 AND ATT	TACH INCOME PRO	OOF REQUIRED IN 3	& 4 BELOW	
 Family Size: Attach last year's Tax Ref. Attach Paycheck Stubs d Total household income in individuals living in the hou 	cludes social security, disabil	ity, student aid, child sup	port and all other forms of	income from all	
I certify that the above inform	nation is true and correct to the	best of my ability.			
	Signature and Date				
DO N	OT WRITE BELOW T	HIS LINE (FOR HO	<u> </u>		
Your Financial Assista	ance Application has been App ance Application has been Den ance Application was denied for	ied. Date or the following reason:	- <u>-</u>	Category B	
Your Financial Assista	ance Application is not comple	te, Please furnish the follow	wing so we can further assist	you in this process:	
Paycheck Stubs n	cceived <u>as required above</u> not received <u>as required above</u> eceived <u>as required above</u>				
Please note: Copays are n	ot covered under financial ca	re program. Patient is li	able.		
Other:		_Provider Signature			
Please mail completed appli	ication to: Mount Nittany M	edical Center. P.O.Box 1	259, State College. PA 1680	4-1259	

Form No. BO-106 Item #00818 Revised1/22/2021