Family Assistance Procedures

1. Guests requesting financial assistance through Family House must contact their hospital social worker and complete Family House, Inc's. "Application for Family Assistance" form. The applicant **WILL** be asked to provide income to the social worker so that she/he may verify the application.

2. The social worker will assist guest in completing application. To determine eligibility for assistance, the income of all adult guests who will be staying in the room will be considered. Assistance begins on the date of application and is not retroactive. The social worker will send pages 1-3 of the Application form to the Family House Housing Office and will retain a copy for the social worker's file. Once reviewed, Family House will contact the social worker to confirm or deny assistance. Assistance (if applicable) is **valid for six months** commencing on application date. Guests must reapply every six month if assistance is still requested. The application is subject to the same process review.

3. Assistance is available on **one room per family or patient**.

4. Assistance is available on all room types.

5. Family Assistance will start the night it is approved. It is not retroactive to check-in date or previous stays.

6. When assessing a family's financial situation, the social worker will ask about Other resources (Pg. 4 of application) reimbursement and whether other financial resources have been explored. If they not are currently receiving reimbursement, the social worker will ask if the family has explored the possibility with their home county caseworker or with some other community resource (Pg. 3 of application).

Special Situation:

When 2 households are in the same room, the social worker will add both incomes together and total the number of people in the households to determine the level of eligibility. Exception: Patient is in the room with required caregiver. Patient's income is evaluated, not the caregiver's. The income and family size determine the amount of assistance. Guest's will be asked to cooperate in using the alternatives before using Family Assistance.

APPLICATION FOR FAMILY ASSISTANCE

Please fax or e-mail Pages 2- 4 of this application to our Housing Office at 412-578-3285. FA applications received after 3 PM will be reviewed the following business day.

FAMILY HOUSE

BEFORE PROCEEDING WITH THIS APPLICATION, PLEASE ANSWER THE FOLLOWING QUESTIONS:

Does patient have Medicaid?
YES   NO

Does patient have any Third Party or Insurance Company reimbursement?
YES   NO

Date: _____

Name of Guest: _____
              Last   First   Middle Initial

Guest is presently in residing at Family House: yes   or   no   (if known)

Patient's HOME COUNTY_____

Name of Patient: _____
                Last   First   Middle Initial

Number of Guests in Room: _____   **Guest's CELL Number:** _____

Hospital: _____   **Physician while in Pittsburgh:** _____

Hospital Designee Name: _____ **Phone:** _____

Hospital Designee Email: _____@_____

Hospital Designee Signature: _____ **Date:** _____
                    Verifying, to the best of your knowledge all of the information in this application is accurate.

For Family House Use Only

Standard Cost of Room: Single $75   Double$99   Quad $116 Quad+ = $125   Kitchenette $130   Apt. $148

Family House Assistance Awarded: _____ Guest Financial Responsibility: _____   (This rate applies to the guest name ONLY)

Family House Approve/Deny: _____   Reason: _____ Date Effective: _____

APPLICATION FOR FAMILY ASSISTANCE

Please fax or e-mail Pages 2-4 of this application to our Housing Office at 412-578-3285. **FA applications received after 3 PM will be reviewed the following business day.**

GUEST'S INFORMATION (Person staying in room as primary caregiver)

Name: _____

          Last   First   Middle Initial

Address: _____

          Street   Apt. #

_____

          City   State   Zip Code

Emergency Number: _____ **Relationship to Patient:** _____

Employer Name: _____

Employer Address: _____

                                         Street

_____

          City   State   Zip Code

SOURCES OF INCOME:

	1 Month	Prior Year Tax Return
From Fundraiser		
Wages/Self-Employment		
Public Assistance		
Social Security		
Unemployment/Worker's Compensation		
Alimony and/or Child Support		
Pension, Dividends, Interest, Rent		
Other Income		
Subtotal		
Total Annual Family Income	**X12 =**	

Please Note: You may be asked to show documentation of your income.

Number of Persons in your Household: _____

Guest's Signature*: _____ **Date:** _____

APPLICATION FOR FAMILY ASSISTANCE

Please fax or e-mail Pages 2-4 of this application to our Housing Office at 412-578-3285. **FA applications received after 3 PM will be reviewed the following business day.**

FAMILY HOUSE

GUEST'S NAME: _____

| Last | First | Middle Initial |

OTHER RESOURCES:
Have the following resources been applied for? Check all that apply and explain below, if needed:

- ☐ Department of Public Welfare/Assistance Reimbursement
- ☐ Insurance Coverage for Housing/Meals
- ☐ Alternative Treatment Based Resource
    - ☐ American Cancer Society
    - ☐ Help • Hope • Live
    - ☐ WV Catastrophic Fund
    - ☐ CASEY fund
    - ☐ Medicaid – State Level
    - ☐ Other Resource: _____

Other information you, the guest, would like us to consider in determining your eligibility:

_____

_____

_____

_____

_____

Clinical Assessment (other relevant factors)

_____

_____

_____

_____