Family House Family Assistance Application

Family Assistance Procedure

FAMILY HOUSE

1. Guests requesting financial assistance through Family House must contact a licensed medical professional to complete Family House, Inc's. "Application for Family Assistance" form. The applicant will be asked to list income to the medical professional so they may verify the application.
2. The licensed medical professional 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.
3. The licensed medical professional will send Pg. 2-4 of the Application form to the Family House Housing Office and will retain a copy for their file.
4. Once reviewed, Family House will contact the medical professional to confirm or deny assistance.

Family Assistance Policy

- FA is available on one (1) room per family or patient and is available on all room types.
- FA applications may not be submitted at Family House; they must be faxed over from the hospital with a licensed medical professional's signature.
- FA will be implemented the day the application is received if it is received before 3:00 P.M. Applications received after 3:00 P.M. will be reviewed on the following business day.
- FA is not retroactive to check-in date or previous stays.
- Assistance is valid for six (6) months commencing on approval date. Guests must reapply every six (6) months if assistance is still requested. The application is subject to the same review process.
- FA is not allowed in conjunction with any other discounts, any third party payers, or reimbursements.
- If income is not listed, or is reported as zero ($0), the application is automatically denied.
- When assessing a family's financial situation, the licensed medical professional will ask about other resources (Pg. 4), reimbursement, and whether other financial resources have been explored.
- If a guest is not currently receiving reimbursement, the medical professional will ask if the family has explored the possibility with their home county caseworker or with another community resource (Pg. 3). Guests will be asked to cooperate in using the alternatives before using Family Assistance.

Special Case

- When two (2) households are in the same room, the medical professional will add both incomes and total the number of people in the households to determine the level of eligibility.
- Exception: Patient is in the room with required caregiver. In that case, the patient's income is evaluated, not the caregiver's. The income and family size determine the amount of assistance.

Application for Family Assistance

Please fax or email Pg. 2-4 of this application to our Housing Office at **412-578-3285** or **housing@familyhouse.org**. FA applications received after 3:00 P.M. will be reviewed the following business day.

Before proceeding with this application, please answer the following questions:

Does the patient have Medicaid?

YES NO

Does the patient have any third party insurance company reimbursement?

YES NO

Guest's Information (person staying in room as primary caregiver):

Name: _____ Cell number: _____ Date: _____
First, middle initial, last

Address: _____

Emergency number*: _____ Relationship to patient: _____
*That of anyone not residing at Family House

Guest is currently residing at Family House: YES NO (if known)

Employer name: _____

Employer address: _____

Name of patient: _____

Patient's home county: _____ Patient's home state: _____

Hospital: _____

Physician(s) while in Pittsburgh: _____

Number of guests in the room: _____

Application for Family Assistance (Continued)

Sources of Income

	Per month	Prior year tax return
Fundraiser	$	
Wages/Self-employment	$	
Public Assistance and/or Food Stamps	$	
Security	$	
Unemployment/Workers Compensation	$	
Alimony and/or Child Support	$	
Pension, Dividends, Interest, Rent	$	
Other Income	$	
Subtotal		
Total Annual Family Income	**x12=**	

Please note: we may ask for documentation of income.

Number of persons in household: _____

Guest's signature*: _____ **Date**: _____

*Verifying, to the best of your knowledge all of the information in this application is accurate.

Medical professional name: _____ Phone: _____

Medical professional email: _____

Medical professional signature*: _____ Date: _____

*Verifying, to the best of your knowledge all of the information in this application is accurate.

Other Resources

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

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

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

_____

_____

_____

_____

Clinical Assessment or other relevant factors:

_____

_____

_____

_____

For Family House use only

Standard Cost of Room: Double $99 Quad $116 Quad+ $125 Kitchenette $130 Apt. $148
Family House assistance* Awarded: _____ Guest Financial Responsibility: _____
Family House Approve/Deny: _____ Reason: _____
Date Effective: _____
*This rate applies to the guest name only