Premium Assistance /Financial Assistance Application

MRN:_____ Employee #: _____ **Due by:** 10/31/2025

To apply for premium assistance, you must meet the following guidelines.

You must enroll in WellSpan Plus | You must be a full-time employee | You must be Employed with WellSpan a year or more as of January 1, 2026

☐ I confirm that I will meet these requirements on January 1, 2026

Employee Name: _____ Date of Birth: _____

Home Address: _____
Street City/State Zip

Telephone Number: (H) _____ (C) _____ Best time to call? _____

Household Members – (Include only people listed on yearly tax return and/or significant other)

Name:	Relationship:	DOB:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

Monthly Gross Income Received from ALL Household Members listed above:

Wages/Salaries (before taxes): _____ Pensions/Annuities: _____

Social Security Income:_____ Cash Assistance: _____

Unemployment/WC Compensation: _____ Child Support: _____ Spousal Support:_____

Veteran's Administration (VA) benefits: _____ Unearned Income (Trusts, interest, rental, disability): _____

Household Countable Resources: Please list your available accounts and liquid assets for your household. A liquid asset is defined as cash or any type of negotiable asset that can be converted quickly and easily into cash. Do not include your home, household items, vehicles, IRA, 401 (K) accounts and other non-liquid assets.

Checking: _____ Savings: _____ Stocks/ Bonds/Mutual Funds/Money Market: _____

Trust Fund: _____ Health Savings Acct(HSA)/ (HRA): _____

Certificate of Deposit: _____ Pay Pal: _____

US Savings Bonds: _____ Christmas/Vacation Club: _____

Other (please explain):_____

Verification of Income and resources must accompany application (Please attach the following if applicable):

Attached:

- Yes ☐ No ☐ Complete Federal Tax Return (most recent year). Personal and/or business.
- Yes ☐ No ☐ Current pay stubs for the last 30 days for each working applicant.
- Yes ☐ No ☐ Award letters showing deposits of Social Security, other disability, pension, worker's comp, or unemployment compensation payments.
- Yes ☐ No ☐ 3 current Checking/Savings/Pay Pal statements, all pages. If self-employed – 6 current bank statements.
- Yes ☐ No ☐ Written explanation of all deposits over $100 in bank accounts (excluding direct deposits and social security)
- Yes ☐ No ☐ Verification of all countable resources.
- Yes ☐ No ☐ Child/Alimony supporting documentation
- Yes ☐ No ☐ Documentation of other sources of income
- Yes ☐ No ☐ If the household has no income, letters from persons who are assisting with daily living needs, explaining the help that the persons provide.
- Yes ☐ No ☐ If self-employed, please provide Profit & Loss
- Yes ☐ No ☐ Verification of all monthly expenses for Medicare eligible applicants.

Have you applied for Medical Assistance or the HIPP program? Y ☐ or N ☐ If yes, please attach notice

I certify that the information I have provided is true and accurate. I understand that any false information or not giving complete information will void this application.

Applicant's Signature: _____ Date: _____

Important Information:

- ☐ Please complete, sign and date the application.
- ☐ In order to process your application, we do require supporting income information. Please enclose this with your application. We will work with you to assess your qualifications for the program based on information supplied to WellSpan Health. Please understand, we will not share the information you provide – this information is for qualification purposes only.
- ☐ If you have any questions about completing the application or are not sure if you qualify, please contact WellSpan Premium Assistance at premiumassistance@wellspan.org

Email all documents to: premiumassistance@wellspan.org

We want to help. Please submit your completed application promptly!