

Date ____/____/____

Return To:
Patient Financial Services
250 North Shadeland Ave.
Indianapolis, IN 46219

In order for a Financial Assistance request to be processed, the following financial information **MUST** be returned with this completed and signed Financial Assistance Application within twenty-one (21) calendar days. Please do **NOT** send original documents.

- All sources of income for the last three (3) months
- Most recent three (3) months of pay stubs or SSI
- Statements from checking and savings accounts, certificates of deposit, stocks, bonds, money market accounts, etc.
- Most recent state and federal income tax forms including Schedules C, D, E, and F, when applicable, and W2s
- Health insurance cards

If you have any questions, please contact us at (317)962-8516.

Account Information:

Patient Name _____ Account Number _____ Account Balance \$ _____

Guarantor Information:

Name _____ Phone (____) _____
Address _____ SSN _____
Marital Status _____ (Married/Single/Divorced)
of Dependents _____

Guarantor Employment/Income Information:

Company _____ Title _____
Address _____ Salary \$ _____ Per _____ (Weekly/Monthly/Yearly)
of Years _____

Spouse Employment/Income Information:

Company _____ Title _____
Address _____ Salary \$ _____ Per _____ (Weekly/Monthly/Yearly)
of Years _____

Other Monthly Income Information:

VA Benefits \$ _____ Retirement \$ _____ SSI \$ _____
Child Support \$ _____ Unemployment \$ _____ Other \$ _____

Insurance Information:

Has the patient applied for Medicaid? _____ (Y/N) Was the patient approved? _____ (Y/N)

Did the patient have health insurance at the time of this hospital service? _____ (Y/N)

If Yes, please fill out the following:

Name of Insurance _____ Effective Date ____/____/____

Name of Policyholder _____ Policy Number _____

Assets:

Checking Account Balance \$ _____ Savings Account Balance \$ _____

Other Asset(s) Balance(s) \$ _____ (CDs, Stocks, Bonds, Money Market Accounts, etc.)

Total ALL Asset Expenses \$ _____

FINANCIAL ASSISTANCE APPLICATION - Continued

Monthly Expenses:

Rent/Mortgage \$ _____ Utilities \$ _____

Food \$ _____ Charge Cards \$ _____

Auto Payment(s) \$ _____ Auto Insurance(s) \$ _____

Medical Expense(s) \$ _____ Pharmacy \$ _____

Child Care \$ _____ Other \$ _____

Total ALL Monthly Expenses \$ _____

Real Estate:

Estimated Value of Home \$ _____ Mortgage Balance(s) \$ _____

SUPPORT STATEMENT

(To be completed by the person providing support.)

I have been identified by the applicant as providing financial support. Below is a list of services I provide the applicant.

I hereby certify and verify that all of the above information given is true and correct to the best of my knowledge and belief. I understand that my signature will not make me financially responsible for the patient's medical charges.

Signature _____ Date _____

I hereby certify, under penalty of perjury, that the answers I have given are true and correct to the best of my knowledge.

I agree to tell the provider of services within 10 days if there are any changes in my (or the person's on whose behalf I am acting) income, property, expenses, number of persons in the household, or change of address.

I understand that I may be asked to prove my statements, and that my eligibility statements will be subject to verification by contact with my employer, bank, credit providers and property searches.

I understand that the hospital is required by law to keep any information I provide confidential.

I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the hospital from proceeds of any litigation or settlement resulting from such incident.

I understand that if I do not qualify for Financial Assistance, I may appeal that decision in writing with additional documentation. If I am still denied for Financial Assistance, I may be responsible for payment of the outstanding invoice(s).

Signature _____ Date _____