ADDENDUM A-1

Community Health Network

APPLICATION FOR FINANCIAL ASSISTANCE

Your application for financial assistance is welcome. For your convenience we offer two ways to apply for financial assistance.

- Call Customer Service at 317-355-5555. This is the easiest way to apply. In most cases we can work with you to determine if you qualify for financial assistance with one phone call.
- Complete this short application and return it according to directions noted on the bottom of the application.

We will do everything possible to accurately and quickly evaluate your application. The information you provide will be held in strict confidence and will not be used for any purpose other than to assess your need for financial assistance. We will not share this information with any person or organization outside of Community Health Network. The person completing this application must be an adult, 18 years of age or older, who is financially responsible for the payment of unreimbursed medical care provided by Community Health Network.

Please provide the following information so we can better understand how many people are in your family. Dependents may live outside of your primary household residence if they are claimed on your (or your spouses) tax return.

APPLICANT NAME _____ TELEPHONE # _____ EMAIL _____

SOCIAL SECURITY NUMBER __ __ __-__ __-__ __ __ __ DATE OF BIRTH __ __/__ __/__ __ __ __

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE/DEPENDENT FAMILY INFORMATION

	NAME	RELATIONSHIP	SSN	DOB
1			__ __ __-__ __-__ __ __ __	__ __/__ __/__ __ __ __
2			__ __ __-__ __-__ __ __ __	__ __/__ __/__ __ __ __
3			__ __ __-__ __-__ __ __ __	__ __/__ __/__ __ __ __
4			__ __ __-__ __-__ __ __ __	__ __/__ __/__ __ __ __
5			__ __ __-__ __-__ __ __ __	__ __/__ __/__ __ __ __
6			__ __ __-__ __-__ __ __ __	__ __/__ __/__ __ __ __

FAMILY FINANCIAL INFORMATION

What is your monthly household, pre-tax, spendable income from all sources such as, but not limited to: wages, salaries, tips, commissions, pensions, Social Security, interest, investments, rent, royalties, alimony, child support, disability benefits, unemployment compensation, etc.? $

ADDITIONAL QUALIFICATION INFORMATION

1. Did you apply for Medicaid through your home state? ☐ YES ☐ NO Was your application approved? ☐ YES ☐ NO

2. Did you or your spouse have active health insurance at the time of service or up to 75 days prior? ☐ YES ☐ NO

If yes: *Insurance Company Name:* _____ *Policy Number:* _____

I CERTIFY that the information I have provided is a true and accurate representation of my family size and household income. I understand that any misrepresentation of this information will result in a denial of financial assistance. I authorize Community to access additional sources of information to verify my qualification for assistance.

Applicant/Patient Signature _____ Date _____

Spouse Signature (if co-applicant) _____ Date _____

Thank you for your application and for the opportunity you have given us to serve your health care needs. Please return your completed application to: *Fax Number (317-351-7862), Email Address (billinghelp@ecommunity.com) or U. S. Mail Address (1500 N. Ritter Ave. Indianapolis, IN 46219).* We will notify you of our decision in writing within 10 business days of the receipt of your application.