



FINANCIAL ASSISTANCE APPLICATION

Return To:
Indiana University Health
250 N. Shadeland Ave.
Indianapolis, IN 46219

***** IMPORTANT *****

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 W-2s
- Health insurance cards

ACCOUNT INFORMATION:

Patient Name: _____ Account #: _____ 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/Salary)

_____ # of Years: _____

SPOUSE EMPLOYMENT/INCOME INFORMATION:

Company: _____ Title: _____

Address: _____ Salary \$ _____ per _____ (Weekly/Monthly/Salary)

_____ # of Years: _____

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: _____

(Application Continued on Reverse Side)



FINANCIAL ASSISTANCE APPLICATION *(continued)*

OTHER MONTHLY INCOME INFORMATION:

VA Benefits: \$

Retirement: \$

SSI: \$

Child Support: \$

Unemployment: \$

Other: \$

ASSETS:

Checking Account Balance: \$

Saving Account Balance: \$

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

Total ALL Asset Expenses: \$

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 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 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 healthcare 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 Financial Assistance, I may be responsible for payment of the outstanding invoice(s).

Signature:

Date: