Financial Assistance Application

To help us determine if you are qualified to receive financial assistance, complete and return the application. Please submit all requested documents listed on the forms.

If you have any questions or need help completing the application, please call us at 1-866-865-0363.

Mail all documentation to the following address:
Franciscan Alliance
Coordinated Business Office
2434 Interstate Plaza Drive, Suite 2
Hammond, IN 46324

Account Number(s): ___________________

Instructions: Attach copies of:

- Bonds, Money Market, Stocks
- Tax returns and supporting schedules (previous 2 yrs.)
- If retired, Social Security benefits and any pension
- Business Profit and Loss Statement
- If disabled, verification of benefits
- Pay stubs (most recent 3 months)
- Bank statements (most recent 3 months for all accounts)
- W-2's or Unemployment Statement
- Provide a written explanation describing your need for financial assistance
- **Note**: If additional space is needed, attach additional sheets

I have applied for or will apply for State or Federal Medical Assistance

Yes ☐ No ☐ If No, Reason ______________________________

I have a lawsuit, settlement, personal injury, or liability claim pending.

Yes ☐ No ☐ If Yes, provide details ______________________________

I have previously applied for financial assistance at another Franciscan Alliance facility.

Yes ☐ No ☐ Not Sure ☐

If Yes, where ______________________ and when ______________________

Responsible Party/Patient

Guarantor Name		Patient Name		Patient Social Security Number		Patient Birth Date *(Month DD, YYYY)*
Address						
City				State		ZIP Code
Phone	Cell Phone	Family Size *(Patient, Spouse and Dependents)*		Marital Status	Are you claimed on another tax return? Yes No	

Student Full-Time Student Part-Time Student	School

Employment Status Full Time Part Time Self Employed Unemployed	Employer Name

Employer Address	Employer Phone

City	State	ZIP Code

Job Title	Employment Length	Unemployed Date/Length *(Month DD, YYYY)*

Spouse

Name	Social Security Number	Birth Date *(Month DD, YYYY)*
School ☐ Full Time Student ☐ Part Time Student	Phone	Cell Phone

Employment Status ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed	Employer Name

Employer Address	Employer Phone

City	State	ZIP Code

Job Title	Employment Length	Unemployed Date/Length *(Month DD, YYYY)*

Dependents(Living at Home/School)

Full Name	Relationship	Birth Date (Month DD, YYYY)

Bank Account Balances

Account Type (Checking, Savings	Bank Name	Bank Address	Current Acct. Balance
Other Investments and Securities			
IRA, Retirement, 401K, 403B)			
Money Market, Stocks, Bonds, CDs,			
Cash value of life insurance			

Equity in real estate/properties excluding primary residence

Type	Detail	Estimated Property Value	Unpaid Mortgage Balance
Land			
Homes other than Primary Residence			
Rental Property			
Business Property			
Other			

Family Income

Income Description (list all types that apply)	Source	Monthly Income Amount
Responsible Party/Patient Gross Wages, Salary and Tips		
Spouse Gross Wages, Salary and Tips		
Interest/Dividends, Pension, Social Security, Supplemental Security, Retirement Income		
Unemployment, Public Assistance Compensation, Veteran's Payment, Survivor Benefits		
Royalties, Trusts, Estate Income, Strike Benefits, Lottery/Gaming Winnings		
Disability/Worker's Compensation		
Alimony/Child Support		
Other		

Creditors indicate all other payments, e.g., bank payments, credit cards, other medical, etc.

Type	To Whom	Unpaid Balance	Monthly Payment
Mortgage(s)			
Home Equity Loans			
Personal Loans			
School Loans			
Vehicle Loans			
Credit Cards			
Medical: Doctor Liability			
Medical: Hospital Liability			
Other			

Certification

I certify that all information listed and attached is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services provided by Franciscan Alliance or an affiliated entity and I give permission to Franciscan Alliance and all affiliated clinics, hospitals and entities to share the information as necessary to consider my financial assistance request. I hereby grant permission to Franciscan Alliance, its affiliates and representatives or agents to investigate the information contained herein, and to obtain credit reports.

Patient/Responsible Party Signature	Date *(Month DD, YYYY)*
Spouse/Partner Signature	Date *(Month DD, YYYY)*