

## INDIANA REGIONAL MEDICAL CENTER FINANCIAL ASSISTANCE APPLICATION

### APPLICANT INFORMATION

Name/Address/SSN/Phone:		Requesting Extended Payment Plan?  <input type="radio"/> Yes
Date of birth:	E-mail Address:	Cell Phone:

### EMPLOYMENT INFORMATION

Please indicate if you are Employed/Retired/Disabled:		
Current employer (I/A):		
City:	State:	ZIP Code:
Position:	Annual income	

### HOUSEHOLD CO-APPLICANT INFORMATION

Name:		
Date of birth:	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:

### EMPLOYMENT INFORMATION

Please indicate if the co-applicant is Employed/Retired/Disabled:		
Current employer (I/A):		
Employer address:		How long?
City:	State:	ZIP Code:
Position:	Annual income:	

### ADDITIONAL HOUSEHOLD MEMBERS

Name	Relationship to Applicant	Date of Birth	Income (if applicable)

### ACCOUNTS RELATED TO APPLICATION REQUEST

Patient Name:	Account no.	Date of Service:	Amount:

### OTHER ASSETS OR SOURCES OF INCOME

Description	Amount per month or value

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I certify that the above information is true and accurate to the best of my knowledge. I will exhaust all other sources of assistance such as Medicaid, Medicare and/or the Exchanges which may be available for payment of my hospital related services.

I understand that this application is completed so that the hospital can determine my eligibility for uncompensated care services under the hospital's established Financial Assistance guidelines. If any of the information I have given proves to be untrue, I understand that the hospital can re-evaluate my financial status and take whatever action becomes appropriate.

Signature of applicant

Date

Signature of co-applicant, I/A

Date

### ELIGIBILITY DETERMINATION (FOR OFFICE USE ONLY)

Date Received: Verification Completed: Yes          No

TOTAL HOUSEHOLD INCOME: \$                      CATEGORY:

The applicant was approved for a reduction of          of allowable charges.

The applicant was denied for the following reason(s)

UNDER ASSETS REQUIREMENTS    Y    N

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Date of Determination:                      2016 TAX RETURN COMPLETED          Y    N

Expiration Date:

Individual Completing Review: