Indiana University Health

Indiana University Health Financial Assistance
Application Form & Information

Primary Applicant Name: _____

Revision Date 1/2023

Date: _____

Return To: Indiana University Health
1155 W. 3rd St.
Bloomington, IN 47404

Email: FinancialAssistance@IUHealth.org
Phone: 1.888.531.3004
Fax: 1.812.353.2032

About IU Health Financial Assistance Policy

If you are an Indiana resident, as defined in the IU Health Financial Assistance Policy, who receives care via the emergency department, direct admission from a physician's office, or transfer from another hospital, you may be eligible to receive additional assistance if paying your medical bills is a financial hardship and you apply. If you meet the Federal Poverty Level (FPL) criteria below, you may be eligible for financial assistance up to the full amount of your medical bill.

# of Adults in Household	# of Dependents in Household	FPL Income Threshold
1+	0	200%
2+	1+	250%
1	1+	300%

If your income is above these levels but the amount you owe is more than 20% of your annual household income, if you apply, you may be eligible for a discount to reduce your patient balance to 5% of your annual income.

To review the IU Health Financial Assistance Policy in its entirety, please visit: https://iuhealth.org/pay-a-bill/financial-assistance

Required Documentation

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. To ensure timely processing of your application, please return the application within twenty-one (21) calendar days. **Please do not send original documents.**

a. All sources of Income for the Household or the Guarantor for the last three (3) months, including at least one of the following:
    1. Most recent three (3) months of pay stubs or Social Security Benefits;
    2. Most recent state and federal tax returns, complete with all Schedules; or
    3. Most recent W-2 statement.
b. Most recent three (3) statements from checking and savings accounts, certificates of deposit, stocks, bonds and money market accounts.
c. In the event the patient or guarantor's income does not warrant the filing of a federal tax statement, the individual may submit an affidavit attesting to the foregoing.

Additionally, applicants must show proof of Indiana residency and his/her primary address, which may not be a post office box, by submitting two (2) qualifying documents. Qualifying documents may include the below:

1. A utility company, credit card, or other billing:
    a. Issued within sixty (60) days of the application date; and
    b. Containing the applicant's name and residence address.
2. A residence mortgage or similar loan contract, or lease or rental contract, containing:
    a. Applicant's name and residence address; and
    b. Signatures from the parties needed to execute the agreement.
3. A U.S. Postal Service change of address confirmation (Form CNL107) containing the applicant's old and new addresses.
4. An Indiana voter registration card.
5. A survey of the applicant's Indiana property produced by a licensed surveyor containing the applicant's name and residence address.

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Street Address: ____

City: ______________________ State: _______ Zip Code: _______________ Primary Phone: _________________

Primary E-mail: ______________________________________

Has anyone in your household applied for, or been approved for, Financial Assistance at IU Health in the past 12 months?
☐ Yes ☐ No If yes, who? ____

Household Members
Please provide the full name and date of birth for all members. Please complete each box for each household member.

Name *Full Name – First Name, MI, Last Name*	**Date of Birth**	**SSN**	**Marital Status**	**Tax Filing Status**	**Applying for Financial Asst.**
				☐Single ☐Married Filed Jointly ☐Married Filed Separately ☐Head of Household ☐Qualifying Widow ☐Does not File Taxes	☐ Yes ☐ No
				☐Single ☐Married Filed Jointly ☐Married Filed Separately ☐Head of Household ☐Qualifying Widow ☐Does not File Taxes	☐ Yes ☐ No
				☐Single ☐Married Filed Jointly ☐Married Filed Separately ☐Head of Household ☐Qualifying Widow ☐Does not File Taxes	☐ Yes ☐ No
				☐Single ☐Married Filed Jointly ☐Married Filed Separately ☐Head of Household ☐Qualifying Widow ☐Does not File Taxes	☐ Yes ☐ No
				☐Single ☐Married Filed Jointly ☐Married Filed Separately ☐Head of Household ☐Qualifying Widow ☐Does not File Taxes	☐ Yes ☐ No
				☐Single ☐Married Filed Jointly ☐Married Filed Separately ☐Head of Household ☐Qualifying Widow ☐Does not File Taxes	☐ Yes ☐ No

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Insurance Information

Please indicate if any you or anyone in your household has any of the following insurance:

Has the household applied for Medicaid? ❑ Yes ❑ No If Not Applied, Please Provide Reason: _____

If yes, provide Application Date: _____ Application Status: ❑ Pending ❑ Approved ❑ Denied

Did any members of the household have health insurance at the time of their hospital service(s)? ❑ Yes ❑ No

If yes, please fill out the following:

Name of Policy Holder	Name of Insurance	Effective Date	Policy Number/ Group Policy Number	Name(s) of Members Covered

Household Employment/Income

If unemployed and receiving unemployment benefits, please list that information in "Other Household Income" section.

Household Member	Employer Name, Address & Job Title *Provide Employer Name if Applicable.*	Income Amount *(Per period of payment at right)*	Period *Select one*	Start Date	End Date *(If Applicable)*
			❑Weekly ❑Monthly ❑Biweekly ❑Annually ❑Hrly # hrs/wk _____		
			❑Weekly ❑Monthly ❑Biweekly ❑Annually ❑Hrly # hrs/wk _____		
			❑Weekly ❑Monthly ❑Biweekly ❑Annually ❑Hrly # hrs/wk _____		
			❑Weekly ❑Monthly ❑Biweekly ❑Annually ❑Hrly # hrs/wk _____		

Other Household Income

Please indicate if you or anyone in your household receives any of the following monthly income:

Type	Household Member	Monthly Amount	Type	Household Member	Monthly Amount
VA Benefits:			Unemployment:		
Child Support:			SSI/SSD/SSDI:		
Retirement:			Other:		

Household Summary

Please record the total amounts calculated in the above fields:

Total Household Size	Total Household Income	Total Other Household Income

Assets/Resources

Please indicate if you or anyone in your household has any of the following assets/resources:

Household Member	Type	Value
	Total Checking Account(s)	
	Total Savings Account(s)	
	Other (CDs, Stocks, Bonds, Money Markets, etc.)	
	Total ALL Assets:	

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	Expenses *Please indicate if you or anyone in your household has any of the following monthly expenses:*				
Expense:	**Household Member**	**Monthly Expense Amount:**	**Expense:**	**Household Member**	**Monthly Expense Amount:**
Rent/Mortgage			Utilities		
Food			Credit Cards		
Auto Payment(s)			Auto Insurance		
Medical Expense(s)			Pharmacy		
Child Care			Other		
				Total ALL Monthly Expenses:	

Verification and Authorization
(To be completed by all Household Adults)

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 IU Health within ten (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 and hereby authorize IU Health and its designees to perform said verification.

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

I agree to allow employees and contractors of IU Health to contact any household adult identified in this application to obtain all information that is necessary to complete and process this application.

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).

Adult Signature: _____ Date: _____

Printed Name: _____

Adult Signature (If Applicable): _____ Date: _____

Printed Name: _____

Adult Signature (If Applicable): _____ Date: _____

Printed Name: _____

Adult Signature (If Applicable): _____ Date: _____

Printed Name: _____