Indiana University Health

Indiana University Health Financial Assistance Application Form & Information

Revision Date 11/2015

Patient Name: ____________________________________ MRN: _________________

Date:_________________

Return To: Indiana University Health
1200 W. White River Blvd.
Muncie, IN 47303
Email: FinancialAssistance@IUHealth.org
Fax: 317-968-1255

Facility Encounter Number	Admit Date	Total Charges

NOTE: THIS APPLICATION WILL BE APPLIED TO THE ABOVE STATED ENCOUNTER ONLY. PATIENTS WITH MULTIPLE ENCOUNTERS WILL NEED TO SUBMIT SEPARATE APPLICATIONS FOR EACH ENCOUNTER.

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. To ensure timely processing of your application, please return the 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 Supplemental Security Income (SSI administered via Social Security)
- Most recent three (3) 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 & F
  - *In the event the patient's and/or guarantor's income does not warrant the filing of a federal tax statement, the patient may submit a notarized affidavit attesting to the foregoing.*
- Most recent W-2 statement
- A copy of health Insurance cards, if insured
- Wage Inquiry from WorkOne *(for Household Members on unemployment)*
- If applicable, divorce/dissolution decrees and child custody order
- *Notice: Your Financial Assistance Application will not be processed until you have fulfilled your $100.00 non-refundable deposit toward your balance. Please include your check made payable to Indiana University Health with your application. All payments made toward an outstanding non-refundable deposit balance will be applied to the oldest Financial Assistance Application on file. Please contact the above e-mail address if you have questions concerning your non-refundable and/or outstanding balance.*

Guarantor *(Head of Household)* Name: _______________________________ Relationship to Patient: _______________________

Street Address: ____

City: _________________________________State:_______Zip Code: ________________Home Phone: ____________________

Household Members
Please provide the full name and date of birth for all members. Please include Social Security number and relationship if known.

Name *Full Name – First Name, MI, Last Name*	**Date of Birth**	**SSN**	**Relationship to Guarantor**	**Marital Status**	**US Citizen** Yes or No	**IN Resident** Yes or No
			SELF			

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 Employment/Income

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)*

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			❑Weekly ❑Monthly ❑Biweekly ❑Annually ❑Hrly # hrs/wk _____		
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			❑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:		
Retirement:			Other:		

Assets/Resources

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

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

Real Estate

Estimated Value of Home:	Mortgage Balance(s):

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			Charge Cards		
Auto Payment(s)			Auto Insurance		
Medical Expense(s)			Pharmacy		
Child Care			Other		

Total ALL Monthly Expenses: ____________________

Insurance Information

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

Has the patient applied for Medicaid? ❑ Yes ❑ No If Not Applied, Please Provide Reason: ____________________
If Yes, provide Application Date:______________
Application Status: ❑ Pending ❑ Approved ❑ Denied

Did the patient have health insurance at the time of this hospital service? ❑ Yes ❑ No If yes, please fill out the following:

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Date:__________________

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

Patient/Guarantor Summary Please record the total amounts calculated in the above fields:				
Household Size	**Total Household Income**	**Other Household Income**	**Total Assets**	**Total Expenses**

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: ____________________________________

Verification and Authorization
(To be completed by Patient or Guarantor)

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 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: ____________________________________