INDIANA REGIONAL MEDICAL CENTER
FINANCIAL ASSISTANCE APPLICATION

APPLICANT INFORMATION			
Name/Address/SSN/Phone:			Requesting Extended Payment Plan? o 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

_____

Date of Determination: 2016 TAX RETURN COMPLETED Y N

Expiration Date:

Individual Completing Review: