Financial Assistance Application

Name: _____

Account Number: _____

Important: You may be able to receive free or discounted care.
Completing this application will help Hendricks Regional Health determine if you are eligible for free or discounted services under its Financial Assistance Program.

Please complete this form as soon as possible after the date of service in order for Hendricks Regional Health to determine your eligibility for financial assistance. We will accept your application for up to 240 days following the date of the first post-discharge patient statement.

Guarantor Information				
Name	Date of Birth	Preferred Phone Number		
Home Address	City	State	Zip Code	County of Residence
Applicant's Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐Widow				
Social Security Number	Health Insurance Information	Employer		
Employment Status ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Unemployed				

Please list everyone in your household below - include yourself and all individuals eligible to be listed on your federal tax return. For families larger than five members, please attach a list of additional household members.

Full Legal Name	Date of Birth	Social Security Number	Relationship

Questionnaire	
Did you have health insurance on the date(s) services were provided?	☐ Yes ☐ No
Have you applied for Medicaid or other state or federal assistance? If yes, please specify program: Date applied:	☐ Yes ☐ No
Were the services provided related to any of the following? ☐ Yes ☐ No If yes, ☐ Accident ☐ Crime ☐ Workplace Injury ☐ Other:	If yes, date of injury
Do you have a Health Savings Account (HSA)? If yes, what is the current balance?	☐ Yes ☐ No
Do you participate in a Cost-Sharing or Medi-Share Program? If yes, please list the amount of payment received:	☐ Yes ☐ No

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Presumptive Eligibility

Uninsured patients or guarantors who ***provide proof of eligibility*** for one of the programs listed below, individually or through the benefits provided to their family, are automatically eligible to receive assistance.

Check as many as apply and provide supporting documentation:

☐ TANF	☐ SNAP
☐ WIC	☐ Indiana Free or Reduced Lunch Program
☐ Indiana Children's Special Health Care Services	☐ Low Income Home Energy Assistance Program
☐ State Medicaid Programs (you or a dependent)	☐ Homeless
☐ Patient Deceased with No Estate	☐ Unlisted State or Federal Income Based Program:

If you qualify for financial assistance based on eligibility for one of the programs above, **STOP** – you are done. Please sign the Applicant Certification on the bottom of this page and submit your application with ***proof of eligibility*** for the applicable program(s). Unlisted programs may require additional documentation.

Required Information and Supporting Documentation

Valid Government-Issued Photo ID:

- ☐ Driver's license, passport, etc.

Tax Documents (Submit all that apply):

- ☐ Most recent State and Federal Income Tax forms including Schedules C, D, E and F if filed

Proof of Income for all Household Members (Submit all that apply):

- ☐ Most recent two months of employer/unemployment stubs
- ☐ Self-Employment Worksheet (available online at hendricks.org/FinancialAssistance)
- ☐ Current Year Social Security Benefit Letter (if applicable)
- ☐ Supporting documentation for all additional sources of income (e.g., IRAs, annuities, etc.)
- ☐ WorkOne Authorization form (if currently unemployed)

Proof of Assets:

- ☐ Two most recent statements from all of your checking and savings account(s)

If an applicant does not have any of the listed documents to prove income, he or she may call the Patient Accounts department to discuss other evidence that may be provided to demonstrate eligibility.

Application Certification:

I certify that the information in this application is true and correct to the best of my knowledge. I understand that the information provided may be verified by Hendricks Regional Health and I authorize Hendricks Regional Health to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information or withhold relevant information, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed and I will be responsible for the balance.

_____ _____

Guarantor Signature Date

Submit completed applications:

HRH Medical Group
1100 Southfield Drive
Suite 1370
Plainfield, IN 46168

Need Assistance?

If you have questions about or need assistance to complete this application process, please contact the Patient Accounts department at 317.837.5566
8:00 a.m. to 4:30 p.m. Monday through Friday.