The Methodist Hospitals, Inc

**Financial Assistance Application**

We have attached a Financial Assistance Application for your convenience. Although it can not be completed on-line, you may print and mail the application with the requested supporting documentation that is needed in order to process the application.

Southlake Campus
(219) 738-5508

Financial Services
Methodist Hospital
8701 Broadway Ave
Merrillville, IN 46410

Northlake Campus
(219) 886-6920

Financial Services
Methodist Hospital
600 Grant Street
Gary, IN 46402

**Application Date**_____

**APPLICATION FOR THE METHODIST HOSPITALS, INCORPORATION**
**HELPING HEART & MHHCI**
**FINANCIAL ASSISTANCE PROGRAM**
**Northlake Campus (219) 886-6920 Southlake Campus (219) 738-5508**

**(Please read and initial the statements below)**

**_____This policy applies only to hospital charges and not independent physicians or independent company billings. I understand that I will be asked to provide proof of the information which I have given on this form and I agree to give the Hospital the necessary verification.**

**_____Resources are limited and it is necessary to set limits and guidelines. These limits are not designed to turn away or discourage those in need from seeking treatment. They are in place to assure that the resources that Methodist Hospitals can afford to devote to its patients are focused on those who are most in need and least able to pay, rather than those who choose not to pay. Only medically necessary diagnostic tests and/or medical procedures are eligible for free or discounted services**

**_____Financial assessments and the review of patients' financial information are intended for the purpose of assessing need, as well as, gaining a holistic view of the patients' circumstances. For scheduled services that exceed $900 a current credit report is required by the patient/guarantor**

**_____ The information I provided on this application is true and correct to the best of my knowledge and belief. I understand that the statements I have made on this form are subject to investigation and verification.**

**_____ I understand that a person who receives assistance by giving false information or by failing to report information may be criminally prosecuted under applicable State law.**

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**Patient Name** _____
(Please Print)

**Patient/Guarantor Signature** _____

**Address** _____

**Home Phone #** _____ **Cell Phone #** _____

**Date of Birth** _____ **Social Security Number** _____

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**Scheduled Tests and/or Procedures** _____

**Diagnosis and ICD9 code** _____

**Date of Service or Account #** _____

**APPLICATION FOR THE METHODIST HOSPITALS, INCORPORATION**
**HELPING HEART & MHHCI**
**FINANCIAL ASSISTANCE PROGRAM**

Please help us to assist you in determining your eligibility for free or discounted care on your Methodist Hospital facility bill:

**Family unit (Please complete all information below)**

| Name | Age | Relationship | Meet IRS regulations for Dependent/Support | Employed |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

INCOME INFORMATION

I and/or my spouse or parent(s) receive money. (Circle one) Yes NO
If yes, the money comes from:

A. Supplemental Security income
B. Social Security
C. Veteran's Benefits
D. Railroad Retirement
E. Pension
F. Military Allotment
G. Unemployment Compensation
H. Support Payments
I. Union Benefits
J. Sick Benefits
K. Roomers and Boarders
L. Rental of property
M. Regular money from relatives
N. Other (describe) _____

| Type (letter from above) | Name of Person receiving | For Whom? | Amount | How often? |
|---|---|---|---|---|
| | | | $ | |
| | | | $ | |
| | | | $ | |

Employment Information-Patient

| Current Employer: | |
|---|---|
| Address: | Phone # |
| Start Date | End Date |

Employment Information-Spouse

| Current Employer: | |
|---|---|
| Address: | Phone # |
| Start Date | End Date |

**APPLICATION FOR THE METHODIST HOSPITALS, INCORPORATION**
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Resources (check all that apply)

__Saving Account
__Certificate of Deposit
__Checking Account
__U.S. Savings Bonds
__Stocks or Bonds
__Savings and Loan Association
__Credit Union Shares
__Income Tax refund

__Other money in burial account in bank with funeral director, or with others (Specify) _____
_____

__Other _____
_____
_____

The responses to these questions can be used in addition to family income criteria.

a. Is the head of the household widowed or divorced? _____

b. If divorced, what is the amount of alimony and/or child support received/paid? _____

c. Are there any other medical or financial problems within the family unit? _____

d. Has the patient filed for bankruptcy recently? _____

**Copy of check stubs, bank statements, Income tax forms and any other supporting documents will be required to process your application.**

***Attach an additional sheet of paper if necessary to provide answers.**

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Patient Name _____ (Account #/Date of Service) _____

**ANNUAL INCOME: Copy of most current IRS 1040 Income Tax Return**

**3 MONTHS COMBINED INCOMES:** Please indicate all sources of income.

| | | |
|---|---|---|
| A. Patient/Guarantor | | $_____ |
| B. Spouse | + | $_____ |
| C. Other Income from legal dependents | + | $_____ |
| FAMILY GROSS INCOME | = | $_____ A |

**MONTHLY EXPENSES:** Please indicate your average monthly expenses for the following items:

| | | |
|---|---|---|
| D. Food | | $_____ |
| E. Utilities (gas, electric, water) | + | $_____ |
| F. Auto, gas, or transportation costs such as bus fare | + | $_____ |
| G. Telephone | + | $_____ |
| H. Child Care | + | $_____ |
| I. Prescription Drug Costs | + | $_____ |
| J. Other health care of dental expenses (co-pays) | + | $_____ |
| K. Other - Entertainment_____ | + | $_____ |
| L. Other _____ | + | $_____ |

**(Attach an additional sheet if necessary)**

| | | |
|---|---|---|
| TOTAL | = | $_____**B** |

CREDITORS: Please indicate the amount of all monthly payments and to whom the payment is made.

| | | |
|---|---|---|
| M. Rent/Mortgage* | | $_____ |
| N. Insurance (auto)* | + | $_____ |
| O. Insurance (other)* | + | $_____ |
| P. Other payment* | + | $_____ |
| Q. Other payment* | + | $_____ |
| R. Other payment* | + | $_____ |
| TOTAL | = | $_____**C** |

***Documentation required**

| | | |
|---|---|---|
| TOTAL MONTHLY FAMILY INCOME | | $_____**A** |
| TOTAL MONTHLY EXPENSES | - | $_____**B**+**C** |
| MARGINAL DISPOSABLE INCOME | = | $_____ |

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OTHER SUPPORTING DOCUMENTS to be requested:

_____ **Bank Statements**

_____ **Pay Stubs**

_____ **Receipts**

_____ **Latest Federal Income Tax Return filed**

_____ **Copy of Township**

_____ **Copy of Food Stamp Receipts/forms**

Printed Name of Person Completing Form if other than patient _____

**I UNDERSTAND THAT THE INFORMATION, WHICH I SUBMIT IS SUBJECT TO VERIFICATION BY THE METHODIST HOSPITALS, INC. OR ITS ENTITIES/FACILITIES AND SUBJECT TO REVIEW BY OTHERS REQUIRED. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT**.

Patient Signature _____ Date _____

# AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby certify that the preceding information is true and accurate to the best of my knowledge. I agree to notify The Methodist Hospitals, Inc. of any change in my income status within ten days of such changes. Furthermore, I will apply for any assistance (Medicaid, Medicare, etc.) which may be available to me for payment towards my hospital bill and/or other medical bills. I understand Methodist Hospital reserves the right to obtain a copy of my credit file as part of the application process. *(Application cannot be processed without signature).*

Patient Signature _____ Date _____

**APPLICATION FOR THE METHODIST HOSPITALS, INCORPORATION**
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**WORKSHEET NOTES:**

NAME OF APPLICANT _____

ACCOUNT #(S) _____

DATE APPLICATION RECEIVED _____

ANNUAL FAMILY INCOME _____

CREDIT REPORT AVAILABLE _____

PERCENTAGE FINANCIAL ASSISTANCE PER GUIDELINES _____

DATE OF DETERMINATION _____

AMOUNT APPROVED _____

SUBMITTED BY _____

APPROVED BY (DIRECTOR) _____

DATE ACCOUNT ALLOWED _____

**REFER TO FINANCIAL ASSISTANCE COMMITTEE? _____ WHY?**

**FINANCIAL ASSISTANCE COMMITTEE REVIEW AND DETERMINATION:**

**APPROVED _____ PERCENTAGE _____ DENIED_____**

**APPROVED BY (CFO) _____**