Helping Heart Financial Assistance Program

To help us determine if you are qualified to receive financial assistance, complete and return the application. Please submit all requested documents listed on the forms.

If you have any questions or need help completing the application please contact Financial Services

Southlake Campus
Financial Services
Methodist Hospital
8701 Broadway Ave
Merrillville, IN 46410
219-738-5508

Northlake Campus
Financial Services
Methodist Hospital
600 Grant Street
Gary, IN 46402
219-886-4584

Account Number(s): _____

Instructions: Attach copies of:

- Pay stubs (most recent3 months)
- Tax returns and supporting schedules(previous year)
- If retired, Social Security benefits and any pension
- Financial Institutions (most recent 3 months for all accounts)
- W-2's or Unemployment Statement
- Proof of household expenses (Rent/Mortgage, Utility Bills.)

Note: If additional space is needed, please attached additional sheets

I have applied for or will apply for State or Federal Medical Assistance

☐ Yes ☐ No If No, Reason_____

I have a lawsuit, settlement, personal injury, or liability claim pending for this date of service/treatment of care

☐ Yes ☐ No If Yes, provide details_____

Responsible Party/Patient

Guarantor Name	Patient Name	Patient Social Security Number	Patient Birth Date *(Month DD, YYYY)*
Address			
City		State	ZIP Code
Phone	Cell Phone	Family Size *(Patient, Spouse and Dependents)*	Marital Status
Are you claimed on another tax return? ☐Yes ☐No			
Student ☐Full-Time Student ☐Part-Time Student	School		

Employment Status ☐Full Time ☐Part Time ☐Self Employed ☐Unemployed	Employer Name	
Employer Address		Employer Phone
City	State	ZIP Code
Job Title	Employment Length	Unemployed Date/Length *(Month DD, YYYY)*

Spouse

Name		Social Security Number	Birth Date *(Month DD, YYYY)*
School	☐ Full Time Student ☐ Part Time Student	Phone	Cell Phone
Employment Status ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed		Employer Name	
Employer Address			Employer Phone
City		State	ZIP Code
Job Title		Employment Length	Unemployed Date/Length *(Month DD, YYYY)*

Dependents (Living at Home/School)

Full Name	**Relationship**	**Birth Date (Month DD, *YYYY*)**

Financial Institution Account Balances

Account Type (Checking, Savings)	**Financial Institution Name**	**Financial Institution Address**	**Current Acct. Balance**
Other Investments and Securities			
IRA, Retirement, 401K, 403B)			
Money Market, Stocks, Bonds, CDs,			
Cash value of life insurance			

Equity in real estate/properties excluding primary residence

Type	**Detail**	**Estimated Property Value**	**Unpaid Mortgage Balance**
Land			
Homes other than Primary Residence			
Rental Property			
Business Property			
Other			

Family Income

Income Description (list all types that apply)	Source	Monthly Income Amount
Responsible Party/Patient Gross Wages, Salary and Tips		
Spouse Gross Wages, Salary and Tips		
Interest/Dividends, Pension, Social Security, Supplemental Security, Retirement Income		
Unemployment, Public Assistance Compensation, Veteran's Payment, Survivor Benefits		
Royalties, Trusts, Estate Income, Strike Benefits, Lottery/Gaming Winnings		
Disability/Worker's Compensation		
Alimony/Child Support		
Other		

Expenses indicate all other payments, e.g., bank payments, credit cards, other medical, household expenses etc..

Type	To Whom	Unpaid Balance	Monthly Payment
Credit Cards			
Credit Card Limit			
Medical: Doctor Liability			
Medical: Hospital Liability			
Household Expenses			
Household Expenses			
Household Expenses			
Household Expenses			
Household Expenses			
Household Expenses			

Household Expenses - See Attached Appendix A

Application and documentation must be returned within 30 days in order to avoid a delay of processing your application for assistance. Please do not send in original documents as they will not be returned; copies are much preferred.

Certification

I certify that all information provided and attached is true and correct to the best of my knowledge. I understand that the information is to be used ascertain my ability to pay for services provided by The Methodist Hospitals, Inc. I hereby grant permission to The Methodist Hospitals, Inc. to review the information contained herein. I understand that a person who receives assistance by giving false information or by failing to report information may result to a denial of Financial Assistance. **Only emergency and medically necessary healthcare services are eligible for free or discounted services.**

Patient/Responsible Party Signature	Date *(Month DD, YYYY)*
Spouse/Partner Signature	Date *(Month DD, YYYY)*

Appendix A
Financial Assistance Policy
List of qualifying expenses

Monthly Expenses:

1) **Food**
2) **Rent/mortgage**
3) **Renters/mortgage insurance**
4) **Home Electricity/gas**
5) **Home telephone/cell phone**
6) **Cable tv/internet**
7) **Car payment**
8) **Car insurance**
9) **Car (monthly gas expense)**
10) **Medical bills**
11) **Prescription drugs**
12) **Credit Card Debt**
13) **Child care**
14) **Other Monthly Expenses**