METHODIST HOSPITALS

METHODIST PHYSICIAN GROUP
An Affiliate of Methodist Hospitals

Financial Assistance Program
Documentation Checklist

Please see the Financial Assistance Policy for eligibility requirements. Your application must include copies of any of the following documents that apply to you. Please attach copies, not originals, as we can't return any documents sent with the application. If any of the documents are missing, it will delay the processing of your application.

Attach a copy of the Patient's and/or Guarantor's Driver License; State Identification Card, Visa or other proof of Identity and Residency

If Your Household Has Income:

- Wages, salaries, tips
- Business income
- Social security income
- Pension or retirement income
- Dividends and interest
- Rent and royalties
- Unemployment compensation
- Legal judgments
- Alimony and/or child support
- Workers' compensation income

Attach proof of your household income, which may include:

>Social Security benefit payments and/or pension/retirement distributions

>Award letters for Food Stamps (SNAP) or TANF or Township

>Unemployment or workers' compensation award letters

>Pay stubs for the last 30 days (pay stubs and/or 1099 forms)

>Most recent IRS Form 1040 with schedules or equivalent of Form 1040 for residences of other countries

>If you are self-employed, you must include a full tax return with Schedule C and/or profit and loss statement

>Dividends and Interest shown on bank statements, mutual fund statements, money market accounts, COD's, bonds, stocks, etc.

> Other income, such as trust funds, charitable foundations, etc. (statement from this month or last month)

>Liquid Assets – Cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, real estate (other than primary residence) or other property immediately convertible to cash.

If You Have No Income:

If you have no income, send us a letter of support. The person who provides your support must sign the letter and have letter notarized.

Letter of Denial of Medical Assistance

You need to apply for Medical Assistance and send a copy of your Letter of Denial before we can approve your application.

Your Completed and Signed Financial Assistance Application Form

Please complete all the parts of the form that apply to you. Note that a separate application must be completed for each individual patient who is requesting financial assistance.

If you do <u>not</u> qualify for Financial Assistance <u>based on Income</u>, please talk with a financial counselor about Catastrophic Care Assistance.

Financial Assistance Program

To help us determine if you are qualified to receive financial assistance, complete and return the application to the one of the addresses below. Please attach all requested documents.

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):_____

Name of Patient:	
Patient's Date of Birth (mm/dd/yyyy):	
Patient's Address:	
Patient's City, State, and Zip Code:	
Patient's Cell Phone:	Patient's Daytime Phone:
Patient's Employer's Name:	Patient's Employer's Phone Number:
Patient's Social Security Number:_____. Note: Social Security Number is required for some public health programs, including Medicaid. Providing your Social Security Number will help us know if you can qualify for any public health programs.	

If Guarantor is the Patient – skip this section	
Name of Guarantor	
Guarantor's relationship to Patient:	
Guarantor's Address:	
Guarantor's City, State and Zip Code:	
Guarantor's Cell Phone:	Guarantor's Daytime Phone:
Guarantor Employer's Name:	Guarantor's Employer's Number:

Guarantor Spouse – skip if no Spouse
Name of Guarantor's Spouse:
Guarantor's Spouse's Address:
Guarantor's Spouse's City, State and Zip:
Guarantor's Spouse's phone number:

Does Patient have health insurance? Yes No	If have insurance, what is name of insurer?
Did you apply for Medical Assistance in the past 6 months? Yes No	
If yes, please enclose a copy of the Letter of Denial.	
Do you have a lawsuit, settlement, personal injury or liability claim pending for this date(s) of service/treatment of care? Yes No If Yes, provide details	

Household Information: List ALL members of your household, including dependents, who were on your most recent IRS Form 1040. If you are now divorced or separated, please provide proof. If pregnant, count as two members.		
Name	Relation to Patient	Age
Total number of household members (including the patient):		

Monthly Household Income: Give monthly income for yourself and other household members. Also attach copies of your proof of income and asset documents (see documentation checklist).		
Monthly Gross Income	Self	Spouse and/or Other Household Members
Wages/self-employment	$	$
Social Security	$	$
Pension or retirement income	$	$
Dividends and interest	$	$
Rents and royalties	$	$
Unemployment	$	$
Workers' compensation	$	$
Alimony and child support	$	$
Legal judgments	$	$
Business Income	$	$
Other Income	$	$
Liquid Assets (see checklist) -- if **less than** $10,000, enter $0. If **greater than** $10,000, list dollar amount that exceeds $10,000	$	$
Total Monthly Family Income used to determine eligibility for assistance	$	$

Additional Comments:

Notice: This application is intended to serve as a statement of policy and not as a contract or agreement with any patient or guarantor. This application does not entitle any person to financial assistance. This application does not create and is not intended to create any third party beneficiaries nor is it intended to create any legal rights with regard to any person or entity. The Information provided by patient/guarantor will be used only to determine financial responsibility for charges from Methodist (medical care, including hospital and applicable provider services) and will be kept confidential. The information provided to prove income and

assets will not be returned. The submitted information concerning annual household income and household size is subject to verification by Methodist including, as necessary, obtaining financial information from employers, banks, and other entities listed by me in this application. **Only emergency and medically necessary healthcare services are eligible for free or discounted service.**

Certification: My signature authorizes Methodist to verify all information provided on this form, including authorization to check credit history, employment status, and other third party information sources to determine eligibility, for federal, state, and private medical programs. I certify that the above information is true and accurate to the best of my knowledge. I understand that if any information I have given is determined to be false, it may result in reversing the financial assistance approval and I will be liable for the full amount of all charges. I understand a determination for financial assistance is made solely at the discretion of Methodist.

Guarantor's Signature: _____ Date:_____
Guarantor's Spouse's Signature: _____ Date:_____

Letter of support

Patient medical record number/account number
Supporter's name
Relationship to patient/applicant
Supporter's address

To Methodist Hospitals,:

This letter is to advise that (patient's name) receives little to no income and I am assisting with his/her living expenses. He/She has little to no obligation to me.

By signing this statement, I agree that the information given is true to the best of my knowledge.

Signature of supporter _____ Date _____

Notorized by the below: