



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

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 not qualify for Financial Assistance based on Income, 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 attached 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 Richard Gordon Hatcher Blvd.
 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:	

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: