

FINANCIAL ASSISTANCE APPLICATION

Your application is not complete without proof of income and assets. Please do not send original documents, as we are unable to return these to you. If you report \$0 income, please provide a brief explanation of how you are meeting your monthly expenses. If you would like to provide additional information of any kind you feel will help us better understand your situation, please attach a letter to this application.

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help the hospital determine if you can receive free or discounted services or other public programs that can help pay for your health care. Please submit this application to the hospital.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help the hospital determine whether you qualify for any public programs. Please complete this form and submit to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care as soon as possible from your discharge date or outpatient care. The hospital doesn't have a time limit for submission.

Patient acknowledges that he or she has made a good-faith effort to provide all information requested in the application to help the hospital determine whether the patient is eligible for financial assistance.

YOU MUST PROVIDE PROOF OF GROSS HOUSEHOLD INCOME AND ASSET INFORMATION. THIS MAY BE IN THE FORM OF:

INCOME: (One of the Following)

1. LAST TWO (2) PAY STUBS
2. COPY OF MOST RECENT W2 AND 1099 FORMS
3. MOST RECENT TAX RETURN FORM
4. WRITTEN INCOME VERIFICATION FROM EMPLOYER IF PAID IN CASH.
5. OTHER THIRD-PARTY VERIFICATION (CHILD SUPPORT PAYMENTS; SSI AWARD LETTER)

ASSETS

RECENT BANK STATEMENTS SUPPORTING VALUE LISTED FOR CHECKING/SAVINGS ACCOUNTS.

PATIENT INFORMATION

First Name		Middle Name		Last Name	
Social Security Number	Birth Date	Marital Status M S W D		Sex M F	Telephone No.
Address		City		State	Zip Code
Employment Status: ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Unemployed -- Last date worked: _____				Email:	

RESPONSIBLE PARTY'S INFORMATION

First Name		Middle Name		Last Name	
Social Security Number	Birth Date	Marital Status M S W D		Sex M F	Telephone No.
Address		City		State	Zip Code
Employment Status: ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Unemployed -- Last date worked: _____				Email:	

RESPONSIBLE PARTY'S SPOUSE INFORMATION

First Name		Middle Name		Last Name	
Social Security Number	Birth Date	Sex M F		Telephone No.	
Employment Status: ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Unemployed -- Last date worked: _____					



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DEPENDENTS (List self, spouse and legal dependents)

Name	Age	Relation	Name	Age	Relation
1.			5.		
2.			6.		
3.			7.		
4.			8.		

ASSETS (Must provide proof of value) dollar amount:

Savings Account	_____
Checking Account	_____
Home Value	_____
Other Real Estate	_____
TOTAL	_____

Vehicle Information

Make & Model	Year	Value
1.		
2.		
3.		

GROSS MONTHLY INCOME (Need proof of Income)

Applicant	_____
Applicant Spouse	_____
Social Security Income	_____
V.A. Pension	_____
Pension	_____
Unemployment	_____
Worker's Compensation	_____
Interest Income	_____
Dividend Income	_____
Child Support	_____
Alimony	_____
Income from Rental Property	_____
Other	_____
TOTAL	_____

I qualify for public assistance. ☐ Yes ☐ No

DEBTS

dollar amount:

Home Loan Balance	_____
Car Loan Balance	_____
TOTAL	_____

MONTHLY PAYMENTS

Mortgage	_____
Rent	_____
Utilities (Electricity, Water, Gas) etc.	_____
Transportation Costs	_____
Food	_____
Car Payment	_____
Child Support	_____
Other Expenses	_____
TOTAL	_____

Processing your application may take 10-14 days. If additional information is needed or your balances are currently in a Commerce Bank repayment plan, additional processing time will be needed. During the financial counseling process, we will determine if you qualify for health insurance coverage through federal or state programs such as Medicaid. If you are eligible for one of these programs, we will ask that you apply for coverage. Our team at The WellFund will reach out to you. They can be reached at 812-450-2124 or 855-365-9300 if you have any questions about applying for coverage.

I, (your name) _____,

do solemnly state that the information contained on this application is true and accurate to the best of my knowledge and belief.

Signature of Patient, Parent, Spouse or Legal Representative_____
Date

Mail to: Deaconess Financial Assistance
PO Box 3366, Evansville, IN 47732

Email to: Financial.Assistance@deaconess.com**Phone:** 812-450-3435 **Fax:** 812-450-5261