HARRISON COUNTY HOSPITAL
An affiliate of NORTON HEALTHCARE

FINANCIAL DOCUMENTATION REQUIRED
FOR ALL MEMBERS OF THE HOUSEHOLD

Date:_____

_____

_____

_____

Dear _____,

In an effort to assist you with your medical expenses at Harrison County Hospital, an application for financial assistance is enclosed. Please **complete the application** and **provide copies** of the documentation checked below.

Please note if your account balance is over $500 an outside agency that works with the hospital, Claimaid, will be contacting you to see if you qualify for state funding that may be available. However, failure to cooperate with Claimaid would result in no assistance being given from the hospital.

For the application to be considered, you MUST return the following documents: *(Your application can not be processed for consideration if the requested documentation is not included.)*

__X__ Food Stamps or TANF
If you provide proof of current eligibility for Food Stamps or TANF you do not need to provide any other documentation other than the proof of eligibility letter and filled out application form.

__X__ Federal Tax Return (1040) for the most recent year *(*or IRS Form 4506-T)

__X__ Last Three Months of Financial Information (Checking, Savings and CD's)

__X__ Pay Stubs for the last 13 weeks (or last 7 bi-weekly pay stubs)

__X__Proof of Any Other Income (i.e. Social Security, Child Support, Rental Income, Unemployment, Pension, Self-Employment, etc.)

__X__ Other: If you have no income submit a signed personal statement noting the date you last worked and/or the start date of disability and how primary household expenses are paid.

Other: _____

_____

Please return materials within 10 days or call me to bring the information to my office to be copied. If you have any questions, please feel free to call me **at (812) 738-7846**.

Thank you,

Stephanie Lovings
Financial Counselor
1141 Hospital Drive NW • Corydon, IN 47112 • (812) 738-7846 • (800) 447-4251 ext. 2230 • Fax: (812) 738-8780

Harrison County Hospital **ATTACHMENT # 2**

APPLICATION FOR FINANCIAL ASSISTANCE **ACCOUNT # _____**

I hereby request that Harrison County Hospital make a written determination of my eligibility for financial assistance services. I understand that the information, which I submit concerning my annual income and family size, is subject to verification by this Hospital. I also understand that if the information, which I submit, is determined to be false, such a determination will result in a denial of financial assistance and that I will be liable for charges for services provided.

PLEASE PRINT

1. GUARANTOR (person responsible for payment)

Name: _____DOB:___/____/___ Social Security #: _____
Last First MI
Address:_____ Phone #(_____)_____
Number and Street City State Zip
County:_____ Primary Physician:_____

2. EMPLOYER _____ OCCUPATION_____

Address:_____ Phone #(_____)_____
Number and Street City State Zip

3. PATIENT'S information if different than Guarantor
Name: _____DOB:___/____/___ Social Security #: _____
Last First MI
Address:_____ Phone #(_____)_____
Number and Street City State Zip

4. PATIENT'S Spouse
Name: _____DOB:___/____/___ Social Security #: _____
Last First MI

Address:_____ Phone #(_____)_____
Number and Street City State Zip

SPOUSE'S EMPLOYER _____ OCCUPATION_____

5. Has guarantor filed bankruptcy in the last 12 months? Yes No

6. FAMILY SIZE _____ (All persons claimed on tax return)

7. INCOME: List income for all the family members claimed on your tax return. ***Attach proof of the supporting income***

NAME RELATIONSHIP AGE	NAME RELATIONSHIP AGE
1.	5.
2.	6.
3.	7.
4.	8.

TOTAL AMT. FOR LAST 13 WEEKS	
Gross Wage	$_____
Self-Employment or Personal	$_____
TANF Benefits	$_____
Food Stamps Benefits	$_____
Social Security/Disability	$_____
Unemployment Compensation	$_____
Worker's Compensation	$_____
Child Support	$_____
Pensions	$_____
Income from Dividends, Interest, or Rental	$_____
Other (Please Explain)	$_____

OTHER SUPPORTING DOCUMENTS REQUIRED:

☐ **Bank/Financial Institution Statements**

☐ **Pay Stubs**

☐ **Latest Federal Income Tax Return filed or IRS Form 4506T-EZ**

☐ **Proof of the Supporting Income**

TOTALS $_____

9. **ASSETS** (please provide copies **for last 3 months**)

$_____**Checking Acct Balance**

Financial Institution Name: _____

$_____**Saving Acct Balance**

Institution Name: _____

$_____**Investments (Stocks, Bonds, Mutual Funds, Money Market Account(s), CD's)**

$_____**Retirement Accounts (IRA's, 401K's)**

$_____**Other Assets (please describe)**

_____

$_____ **TOTAL ASSETS**

AUTHORIZATION TO RELEASE INFORMATION

The undersigned certifies the following:

1. Patient and/or guardian has applied for financial assistance with Harrison County Hospital and as part of the application process, it is understood that Harrison County Hospital may verify information contained in patient and/or guardian's application and in other documents such as the patient's credit report which may have been supplied in connection with the financial assistance application.

2. Patient and/or guardian duly authorize you to release and provide to Harrison County Hospital any and all information and documentation that they may request. I give permission to Harrison County Hospital to discuss any accounts which are in the patient and/or guardian's name.

3. A photo or faxed copy of this authorization may be accepted as an original.

_____ _____

Printed Responsible Name Signature Responsible Name

_____ _____

Social Security Number Date

_____ _____

Printed Other Adult's Name Signature Other Adult's Name

_____ _____

Social Security Number Date

I understand that the information which I submit is subject to verification by Hospital. I certify that the above information is true, correct, and complete.