Henry Community Health

**HENRY COMMUNITY HEALTH**
**UNCOMPENSATED CARE**
**MEDICAL FINANCIAL ASSISTANCE PROGRAM**

Thank you for choosing Henry Community Health for your healthcare needs. Attached you will find an application for our Uncompensated Care Financial Assistance Program. This is a program that is provided by Henry Community Health to assist with hospital medical expenses. We would like to take this opportunity to provide an outline of how our program operates and how to accurately complete the application. The hospital utilizes the Federal Income Poverty Guidelines to provide eligibility determinations. Eligibility determinations are based on the gross (before any deductions) yearly household income and not expenses. This is not a health insurance plan but rather assistance for unexpected medical expenses.

1. Complete this form in its entirety on the front side and return to our Central Business office within 10 days.
2. Application approval is based on gross income and family size.
3. **Proof of income is required for your application to be processed. Copies of the last 3 months of pay stubs are required for members of the household. It is also required to provide proof of any and all non-work related sources. These sources are listed on the application. Failure to provide proof of income will result in the application being denied. If you cannot provide the last 12 weeks of income, reason must be documented and approval must be obtained from the Business Office Director before the application can be approved.**
4. Gross household income must be accurately stated for everyone that lives in the household. Gross income is your income before any taxes or deductions of any type are taken out of you wages. Types of income are listed on the form that must be reported. If income is left blank or reported inaccurately, the form will be considered invalid and the application will be denied.
5. For individuals that are separated, you must report the income the absent spouse contributes to the household.
6. **If you have no income, you must explain how your needs of shelter, food, clothing, etc. are met.**
7. Signature is required for form to be valid. If a Power of Attorney or the guardian of a minor is completing the form, the person completing the form is required to sign it along with their relationship to the patient.
8. Your application will be processed within 45 days from the date we receive it back into our office.
9. Once your application is processed you will receive a letter in the mail informing you of the outcome.
10. If there is a balance remaining it will need to be resolved within 60 days. If you are unable to pay the balance within 60 days, you will need to contact our Central Business Office at 765-521-1516.
11. **Our financial assistance program only applies to Henry Community Health, New Castle Family and Internal Medicine, Cambridge City Family Health Partners, Middletown FHP, Pediatrics @ New Castle Family & Internal Medicine, Henry County Anesthesiology and Henry County Radiology. When receiving bills from any other providers you must contact them directly to make necessary arrangements.**
12. Your application is good for a period of 90 days. After that time a new application is required. If income changes in that 90 days period you are required to contact our office.

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# HENRY COMMUNITY HEALTH
# MEDICAL FINANCIAL ASSISTANCE - UNCOMPENSATED CARE APPLICATION

**Please call Patient Accounts at 521-1516 to assist you with any questions regarding this application.**

Date(s) of service: _____ Date of Request: _____

Patient's Name: _____ Phone: _____

Address (street):_____ (City) _____ (Zip)_____

Do you have health insurance or any other healthcare cost-sharing program? _____

If yes, name of that coverage/program: _____

Have you applied for insurance coverage, including Medicare or Medicaid within the last 90 days? _____

**WHAT IS THE HOUSEHOLD GROSS INCOME PER MONTH? $ _____**
**(If separated, must include the amount of income the absent spouse contributes to the household)**

**Please use the lines below to list everyone living in your household and their individual income or if they have an income, to determine household size. Gross income is your income prior to any taxes or any other item being deducted from your total wages.** Please fill out all requested information on each line used below.

**Name Relationship to Patient Age Employer Name Gross Income per Month**

1._____
2._____
3._____
4._____
5._____

## INCOME TO REPORT

| | |
|---|---|
| Earnings from Work<br>Wages/salaries/tips<br>Strike benefits<br>Unemployment compensation<br>Workman's compensation<br>Net income from self-owned business or farm | Pensions/Retirement/Social Security<br>Pensions<br>Retirement income<br>Social Security<br>Veteran payments<br>Supplemental Social Security |
| Welfare/Child Support Alimony<br>Public assistance payments<br>Welfare payments<br>Alimony payments<br>Child support payments | Other Income<br>Earnings from second job<br>Disability benefits<br>Rental Income<br>Interest/Dividends - Cash in savings account(s)<br>Income from Estates/Trusts/Investments<br>Regular contributions from persons not living in the household |

I attest that the information provided above is accurate, true and complete.

**Signature required below.**

_____

***Signature of person making request and relationship if other than the patient**

Henry Community Health

**DO NOT COMPLETE - HOSPITAL PERSONNEL ONLY**

Date application submitted_____ Invoice(s) or Case No_____.

Received by_____

Patient name_____

Service date(s)_____

Date of birth_____

Medicaid applied for and outcome_____

**INCOME CALCULATION:**

TOTAL 3 MONTHS TOTAL 12 MONTHS TOTAL YEARLY INCOME

_____

_____

GRAND TOTAL INCOME FOR HOUSEHOLD:_____

Total Bill_____

Category applicant qualified for_____
(% and household size)

Amount approved_____

Remaining balance_____

**REMARKS**

_____

**Patient Account Representative** **Date**