Johnson Memorial Hospital
1125 W. Jefferson St.
P. 0. Box 669
Franklin, IN 46131

APPLICATION FOR FINANCIAL ASSISTANCE

All sections of this application (*FRONT and BACK*) must be completed.

Name of person requesting the Financial Assistance:_____

Address:_____

_____

Telephone #:_____ Date of Application:_____

Total Amount of Assistance requested: $_____

List all accounts that are to be reviewed for Financial Assistance:

Patient Name:	Account Number:	Amount

➔ A review for Financial Assistance is based upon the level of income for the family & the number of persons in the family. This application must be completed in it's entirety. The application must have the following attachments:

☐ Copy of last 4 pay stubs or other income check stubs ☐ Previous years' Tax Return

☐ Last 2 months utility statements ☐ Most current bank statement(s)

Please state the reason you are requesting Financial Assistance:

_____

_____

Family Income Information: Number of persons in family:_____ Number Employed:_____ Number of Dependents:_____

Dependents Ages	Relationship to You:	Dependents Ages	Relationship to You:	Dependent Ages	Relationship to you
❶ _____	_____	❸ _____	_____	❺ _____	_____
❷ _____	_____	❹ _____	_____	❻ _____	_____

Employer # 1 (Name,Address,Telephone #) Employee Status Weekly GROSS Income

_____ ☐ Full Time # hours worked:_____ $_____

_____ ☐ Part Time #hours worked:_____

_____ How long with this Employer? _____Years_____ Months_____ Weeks

Employer # 2 (Name,Address,Telephone #) Employee Status Weekly GROSS Income

_____ ☐ Full Time # hours worked:_____ $_____

_____ ☐ Part Time #hours worked: _____

_____ How long with this Employer?_____ Years_____ Months_____ Weeks

Other Income: ☐ Child Support: $_____ ☐ SSI $_____ ☐ Disability $_____ ☐ Pension $_____

☐ Unemployment: $ _____ ☐ Worker's Compensation $_____ ☐ Trusts / Savings $ _____

☐ Rent / Royalties: $_____ ☐ Other $_____ Define:_____

❶ **Total Monthly Income: $ _____ (Transfer this amount to be reverse side of this page.)**

Johnson Memorial Hospital

Application for Financial Assistance

Side # 2 - All sections of this application must be completed.

Monthly Expense Information:

Rent: _____ Cell Phone: _____

Mortgage: _____ Cable Bill: _____

Utilities: _____ Telephone: _____

☐ Single Line ☐ Multiple Line ☐ Call Waiting

Child Care: _____ Credit Card: _____

Car Payment: _____ Internet Access: $_____

Life Insurance: _____

Other Medical Expenses (list name of Medical Provider and amount owed:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Other Expenses: (List)

_____ _____

_____ _____

_____ _____

_____ _____

Total Expenses: ❷ $ _____

Total Income (side 1): $ ❶ _____ (minus) Total Expenses: $ ❷ _____ = $_____

ASSETS: Home Value: $_____ Mortgage Balance: $ _____

Bank Accounts:

Name of Bank/Financial Institution	Checking Balance	Savings Balance	CD's	Investments
_____	$_____	$_____	$_____	$_____
_____	$_____	$_____	$_____	$_____
_____	$_____	$_____	$_____	$_____

Motor Vehicle (s) & Value		Other Personal Property & Value	
_____	$ _____	_____	$_____
_____	$ _____	_____	$_____

Verification & Authorization for Release of Information. I certify that the information provided is true and correct to the best of my knowledge. I understand that the statements I have made on this form are subject to investigation and verifications. I understand that I will be asked to provide proof of the information which I have given on this form. I agree to help Johnson Memorial Hospital obtain the necessary verifications. I hereby authorized the release of wage information, financial information from banks and other financial institutions and from the Department of Heath and Human Services to Johnson Memorial Hospital. If review of my financial records reveal that I could be entitled to Medicaid, ☐ **I DO** ☐ **I DO NOT** want Johnson Memorial Hospital, with the help of their consulting service, pursue this opportunity. If you qualify for assistance, Johnson Memorial Hospital can notify other medical providers that you qualified for our Financial Assistance Program. Please indicate your preference by selecting your choice. ☐ **You may**, ☐ **You may NOT** provide information to other medical providers. You will receive a copy of the letter we mail to other medical providers.

Signature of Patient or Legal Guardian: _____ Date: _____

Spouse / Guarantor Signature: _____ Date: _____