Community Health Network

APPLICATION FOR FINANCIAL ASSISTANCE

Thank you for giving us the opportunity to serve your healthcare needs and for expressing interest in our Financial Assistance Program.

Please complete this application and return it along with **all supplemental documentation required within 15 days** to avoid possible denial of your application. The information you provide will be held in strict confidence and will not be used for any purpose other than to assess your need for financial assistance. We will not share this information with any person or organization outside of Community Health Network.

Please provide the following information completely and accurately. Information is subject to verification. Please attach a list of additional household members if there are more than five (5) members.		
Patient Name (First, MI, Last)	SSN (Optional)	Total # of household members
Address	Date of Birth	Home/Cell Phone
City/State/Zip		Work Phone
Guarantor Name	Account #	

Dependents may live outside of your primary household residence if they are claimed on you or your spouse's tax return.

List ALL household members names	Date of Birth	SSN (Optional)	Relationship to Patient	Insurance
1				Yes/No
2				Yes/No
3				Yes/No
4				Yes/No
5				Yes/No

Gross monthly income, compared to the Federal Poverty Level (FPL) guidelines, will be considered in determining financial assistance eligibility. Monthly expenses may be considered on an exception basis in determining financial assistance eligibility.

Gross Monthly Income (before taxes) All Sources		Monthly Expenses	
Household Gross Income (before taxes):	$	Mortgage/Rent	$
Pension:	$	Electricity/Gas/Water/Trash	$
Retirement:	$	Household (Internet/Cable/Phone/Groceries)	$
Social Security Income (SSII):	$	Homeowners/Renter Insurance	$
Unemployment:	$	Auto (Payments/Insurance)	$
Additional Income:	$	Health Insurance	$
Additional Income:	$	Medical & Pharmacy	$
Additional Income:	$	Child Care	$
Additional Income:	$	Credit Card(s)	$
Additional Income:	$	Student Loans	$
Additional Income:	$	Other	$
Total Income		Total Expenses	

I CERTIFY that the information I have provided is a true and accurate representation of my family size and household income. I understand that any misrepresentation of this information will result in denial of financial assistance. I authorize Community Health Network to access additional information, including prior year tax filings (1040 schedules C, D, E & F or 1040 EZ), to verify my qualification for assistance.

Applicant/Patient Signature _____ Date _____

Spouse Signature (if co-applicant) _____ Date _____

Thank you for your application and for the opportunity you have given us to serve your health care needs. Please return your completed application and all supporting documentation to: **Fax Number: 317.355.8778, Email: billinghelp@ecommunity.com or U.S. Mail Address: 6435 Castleway West Drive, Indianapolis, IN 46250.**