2903 West Jackson Street
Muncie, In 47304
Local (765) – 751-5370
Toll Free (888) 531-3004

Date:

Dear:

Enclosed please find a Financial Assistance Application to be used for determining your eligibility for assistance. In order for your request for assistance to be processed, you will need to complete the entire application, sign the application, and submit copies of the following items within 10 calendar days from the date of this letter:

- All sources of income for the entire household
- Most recent pay-stub, unemployment stub, SSI, pension, child support income
- Statements from checking and savings accounts, certificates of deposit, stocks, bonds, money market accounts, etc.
- Most recent 1040 federal income tax forms including schedules C, D, E, and F when applicable
- Health Insurance Cards

It is important that you return all of the above items, including the completed and signed Financial Application, in the self addressed envelope to the Financial Counseling Services office at 2903 West Jackson Street, Muncie, In 47304. Your request will not be processed without the above information.

If you have questions or difficulty in obtaining the necessary information, please call our office at (765) 751-5370 or 1-888-531-3004.

Sincerely,

Financial Counselor
Patient Financial Services
Effective 06/18/2009

Financial Assistance

APPLICATION

Date of Application ______

Grey areas to be completed by Hospital Personnel

Patient Name ______ Acct. # ______ $ ______

Social Security # ______ Acct. # ______ $ ______

Guarantor Name ______ Phone # ______ Acct. # ______ $ ______

Spouse / Partner ______ Children / Ages ______ Acct. # ______ $ ______

ASSETS / INCOME

Checking ______ Balance ______

Savings ______ Balance ______

Stocks/Bonds/CD's ______

401K's / IRA's ______

Other Assets (vehicles, cash value life insurance policy) ______

Rental Property Address / Income: ______

Other Income (unemployment, social security) ______

Patient Employer ______

Gross Income ______

Guarantor Employer ______

Gross Income ______

Spouse / Partner Employer ______

Gross Income ______

Pension Child Support ______

BASIC LIVING EXPENSES

SHELTER

House / Rent Payment ______ Lot Fee ______

House Taxes ______ Insurance ______

UTILITIES

Gas / Propane ______ Electric ______

Phone ______ Water ______ Heater / Softener ______

Sewage ______ Cable ______

PERSONAL CARE

Groceries ______ Food Stamps ______

Medical Insurance ______ Medication ______

Household Goods ______

TRANSPORTATION

Vehicle Payment #1 ______

Vehicle Payment #2 ______

Car Insurance ______

Bus / Cab / Gasoline ______

Child Support ______

Child Care ______

Net Income ______

Total BL Expenses ______

Disp. Income (+ / -) ______

Debt to Income Ratio (DIR) ______

OTHER DEBT OBLIGATIONS

Credit Card ______ Balance ______ Limit ______ School Loan ______ Balance ______

Credit Card ______ Balance ______ Limit ______ Other Loan ______ Balance ______

Credit Card ______ Balance ______ Limit ______ Other Debt ______ Balance ______

Credit Card ______ Balance ______ Limit ______ Other Debt ______ Balance ______

Medical Bills ______ Provider ______ Balance ______ Cell Phone / Pager ______

Medical Bills ______ Provider ______ Balance ______ Financial Application

Medical Bills ______ Provider ______ Balance ______ Taken by: ______

I affirm that the information contained in this application is accurate and to the best of my knowledge represents my financial situation. I authorize the above named institutions to release to hospital personnel any financial information on file concerning the patient responsible parties listed on this application. I also grant permission to hospital personnel to review my credit report file for debt verification.

______
APPLICANT SIGNATURE

☐ Full / Partial Financial Assistance

☐ Denied Financial Assistance

Authorized Signature ______

AB-102 (09/09)