

FINANCIAL ASSISTANCE APPLICATION

Please complete this application as fully as possible and return within ten working days. Your application is not complete without proof of income and assets. Please do not send original documents, as we are unable to return these to you. If you report \$0 income, please provide a brief explanation of how you are meeting your monthly expenses. If you would like to provide additional information of any kind that you feel will help us better understand your situation, please attach a letter to this application.

YOU MUST PROVIDE PROOF OF GROSS HOUSEHOLD INCOME AND ASSET INFORMATION. THIS MAY BE IN THE FORM OF:

INCOME

1. LAST FOUR PAY STUBS
2. LAST YEAR'S FEDERAL (1040) TAX RETURN & ANY SCHEDULES
3. SOCIAL SECURITY INCOME AWARD LETTER OR 1099
4. CHILD SUPPORT PAYMENT STATEMENT

ASSETS

1. RECENT BANK STATEMENTS SUPPORTING VALUE LISTED FOR CHECKING/SAVINGS ACCOUNTS, CDs, SECURITIES, AND/OR FINANCIAL SETTLEMENTS

Please print all information using BLACK ink only

PATIENT INFORMATION

First Name		Middle Name		Last Name	
Social Security Number		Birth Date	Marital Status M S W D		Sex M F
Address		City		State	Zip Code
Occupation	Employer		Length of Employment	Full Time Part time	Hours per Week

RESPONSIBLE PARTY'S INFORMATION

					Email:
First Name		Middle Name		Last Name	
Social Security Number		Birth Date	Marital Status M S W D		Sex M F
Address		City		State	Zip Code
Occupation	Employer		Length of Employment	Full Time Part time	Hours per Week

RESPONSIBLE PARTY'S SPOUSE INFORMATION

First Name		Middle Name		Last Name	
Social Security Number		Birth Date		Sex M F	Telephone No.
Occupation	Employer		Length of Employment	Full Time Part time	Hours per Week

DEPENDENTS (List self, spouse and legal dependents)

Name	Age	Relation	Name	Age	Relation
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Continued on other side

ASSETS (Must provide proof of value) dollar amount:

Cash on Hand	_____
Savings Account	_____
Checking Account	_____
CDs	_____
Securities	_____
Home Value	_____
Other Real Estate	_____
Other	_____
TOTAL	_____

Vehicle Information

Make and Model	Year	Value
1.		
2.		
3.		

GROSS MONTHLY INCOME (Need proof of Income)

Applicant	_____
Applicant Spouse	_____
Social Security Income	_____
V.A. Pension	_____
Pension	_____
Unemployment	_____
Worker's Compensation	_____
Interest Income	_____
Dividend Income	_____
Child Support	_____
Alimony	_____
Income from Rental Property	_____
Other	_____
Other	_____
TOTAL	_____

I qualify for Food Stamps. Yes No

FINANCIAL SETTLEMENTS (Must provide proof of value):

Insurance	_____
Inheritance	_____
Other	_____
TOTAL	_____

I, (your name) _____, do solemnly state that the information contained on this application is true and accurate to the best of my knowledge and belief.

Signature of Patient, Parent, Spouse or Legal Representative

Date

DEBTS dollar amount:

Home Loan Balance	_____
Car Loan Balance	_____
Credit Card Balances:	
1.	_____
2.	_____
3.	_____
Other Debts:	
_____	_____
_____	_____
_____	_____
_____	_____
TOTAL	_____

MONTHLY PAYMENTS

Mortgage (PITI)	_____
Rent	_____
Utilities (Electricity, Water, Gas, etc.)	_____
Gas for Vehicle(s)	_____
Telephone/Cell Phone	_____
Cable/Internet	_____
Groceries/Household Necessities	_____
Furniture	_____
Car Payment	_____
Clothing	_____
Day Care	_____
Child Support	_____
Alimony	_____
Credit Cards	_____
Commerce Bank Repayment Plan	_____
Payments on Medical Bills:	
1.	_____
2.	_____
Insurance:	
Auto	_____
Property	_____
Medical	_____
Loan Payments:	
1.	_____
2.	_____
TOTAL	_____

Mail to: Deaconess Financial Assistance
P.O. Box 3366, Evansville, IN 47732

Email to: Financial.Assistance@deaconess.com

Phone: 812-450-3435 **Fax:** 812-450-5261

Processing your application may take 10-14 days. If additional information is needed or your balances are currently in a Commerce Bank repayment plan, additional processing time will be needed. During the financial counseling process, we will determine if you qualify for health insurance coverage through federal or state programs such as Medicaid. If you are eligible for one of these programs, we will ask that you apply for coverage. Our team at The WellFund will reach out to you. They can be reached at 812-450-2124 or 855-365-9300 if you have any questions on applying for coverage.