BAPTIST HEALTH DEACONESS MADISONVILLE

FINANCIAL ASSISTANCE APPLICATION

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.

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help the hospital determine if you can receive free or discounted services or other public programs that can help pay for your health care. Please submit this application to the hospital.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help the hospital determine whether you qualify for any public programs.

Please complete this form and submit to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care as soon as possible from your discharge date or outpatient care. The Hospital doesn't have a time limit for submission.

Patient acknowledges that he or she has made a good-faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.

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

INCOME: (One of the Following)

1. LAST TWO (2) PAY STUBS
2. COPY OF MOST RECENT W2 AND 1099 FORMS
3. MOST RECENT TAX RETURN FORM
4. WRITTEN INCOME VERIFICATION FROM EMPLOYER IF PAID IN CASH.
5. OTHER THIRD-PARTY VERIFICATION (CHILD SUPPORT PAYMENTS; SSI AWARD LETTER)

ASSETS

RECENT BANK STATEMENTS SUPPORTING VALUE LISTED FOR CHECKING/SAVINGS ACCOUNTS.

PATIENT INFORMATION

First Name	Middle Name	Last Name		
Social Security Number	Birth Date	Marital Status M S W D	Sex M F	Telephone No.
Address	City	State	Zip Code	
Employment Status: ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Unemployed -- Last date worked: _____	Email:			

RESPONSIBLE PARTY'S INFORMATION

First Name	Middle Name	Last Name		
Social Security Number	Birth Date	Marital Status M S W D	Sex M F	Telephone No.
Address	City	State	Zip Code	
Employment Status: ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Unemployed -- Last date worked: _____	Email:			

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RESPONSIBLE PARTY'S SPOUSE INFORMATION

First Name	Middle Name	Last Name	
Social Security Number	Birth Date	Sex M F	Telephone No.

Employment Status: ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled
☐ Unemployed -- Last date worked: _____

DEPENDENTS (List self, spouse and legal dependents)

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

ASSETS (Must provide proof of value) dollar amount:

Savings Account _____
Checking Account _____
Home Value _____
Other Real Estate _____
TOTAL _____

Vehicle Information

Make & Model	Year	Value
1.		
2.		
3.		

DEBTS dollar amount:

Home Loan Balance _____
Car Loan Balance _____
_____
TOTAL _____

MONTHLY PAYMENTS

Mortgage _____
Rent _____
Utilities (Electricity, Water, Gas) etc. _____
Transportation Costs _____
Food _____
Car Payment _____
Child Support _____
Other Expenses _____
_____
TOTAL _____

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 _____
TOTAL _____

I qualify for public assistance. ___ Yes ___ No

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 about applying for coverage.

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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

Mail to: Deaconess Financial Assistance
PO Box 3366, Evansville, IN 47732

Email to: Financial.Assistance@deaconess.com

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