HENRY COMMUNITY HEALTH
UNCOMPENSATED CARE
MEDICAL FINANCIAL ASSISTANCE PROGRAM

Thank you for choosing Henry Community Health for your healthcare needs. Attached you will find an application for our Uncompensated Care Financial Assistance Program. This is a program that is provided by Henry Community Health to assist with hospital medical expenses. We would like to take this opportunity to provide an outline of how our program operates and how to accurately complete the application. The hospital utilizes the Federal Income Poverty Guidelines to provide the eligibility determinations. Eligibility determinations are based on the gross (before any deductions) yearly household income and not expenses. This is not a health insurance plan but rather assistance for unexpected hospital medical expenses.
If you are contacted by a representative of ClaimAid to assist you with a Medicaid or Healthy IN Plan (HIP) application, you must fully cooperate with them. If non compliant with ClaimAid requirements you will not be eligible for our medical assistance program for your hospital services.

1. Complete this form in its entirety on the front side and return to our Central Business office within 10 days.
2. **Proof of income is required for your application to be processed. Copies of the last 3 months of pay stubs are required for members of the household. It is also required to provide proof of any and all non-work related sources. These sources are listed on the application. Failure to provide proof of income will result in the application being denied. If you cannot provide the last 12 weeks of income, reason must be documented and approval must be obtained from the Business Office Director before the application can be approved.**
3. Gross household income must be accurately stated for everyone that lives in the household. Gross income is your income before any taxes or deductions of any type are taken out of you wages. Types of income are listed on the form that must be reported. If income is left blank or reported inaccurately, the form will be considered invalid and the application will be denied.
4. For individuals that are separated, you must report the income the absent spouse contributes to the household.
5. **If you have no income, you must explain how your needs of shelter, food, clothing, etc. are met.**
6. Signature is required for form to be valid. If a Power of Attorney or the guardian of a minor is completing the form, the person completing the form is required to sign it along with their relationship to the patient.
7. Your application will be processed within 45 days from the date we receive it back into our office. This time frame could be longer if you are pending a Medicaid determination.
8. Once your application is processed you will receive a letter in the mail informing you of the outcome.
9. If there is a balance remaining it will need to be resolved within 60 days. If you are unable to pay the balance within 60 days, you will need to contact our Central Business Office at 765-521-1516.
10. **Our financial assistance program only applies to Henry Community Health, New Castle Family and Internal Medicine, Cambridge City Family Health Partners, Pediatrics @ New Castle Family & Internal Medicine, Henry County Anesthesiology and Henry County Radiology. When receiving bills from any other providers you must contact them directly to make necessary arrangements.**
11. Your application is good for a period of 90 days. After that time a new application is required. If income changes in that 90 days period you are required to contact our office.

HENRY COMMUNITY HEALTH
MEDICAL FINANCIAL ASSISTANCE - UNCOMPENSATED CARE APPLICATION

Please call Patient Accounts at 521-1516 to assist you with any questions regarding this application.

Date(s) of service: ______________ Date of Request: ________________

Patient's Name: ______________ ________________ Phone: __________________

Address (street):___________________(City) _________________ (Zip)_________

Do you have insurance, any type of coverage, belong to a Christian Healthcare Sharing Program, or any other healthcare cost-sharing program?
If yes, name of that coverage/program: Anthem Draper
It must be billed and finalized prior to your application being processed for assistance.

Have you applied for Medicaid within the last 90 days? No Marital Status: _________________

WHAT IS THE HOUSEHOLD'S GROSS INCOME PER MONTH? $ ____________________________

Please use the lines below to list everyone living in your household and their individual income, if they have an income, to determine household size. Gross income is your income prior to any taxes or any other item being deducted from your total wages. Please fill out all requested information on each line used below.
****If separated, must include amount of income the absent spouse contributes to the household.$__________**

Name Relationship to Patient Age Employer Name Gross Income per Month

1.____
2.____
3.____
4.____
5.____

INCOME TO REPORT

Earnings from Work	Pensions/Retirement/Social Security
Wages/salaries/tips Strike benefits Unemployment compensation Workman's compensation Net income from self-owned business or farm	Pensions Retirement income Social Security Veteran payments Supplemental Social Security
Welfare/Child Support Alimony	**Other Income**
Public assistance payments Welfare payments Alimony payments Child support payments	Earnings from second job Disability benefits Rental Income Interest/Dividends - Cash in savings account(s) Income from Estates/Trusts/Investments Regular contributions from persons not living in the household

I understand that the information, which I submit, is subject to verification by Henry Community Health, and subject to review by federal and/or state enforcement agencies and others as required. Under the penalty of perjury, I affirm that the above information is true and correct and I have reported all income. Signature also indicates my permission for the Hospital to contact Henry County Resources (Welfare Dept.) to verify the date of Medicaid application and its current status.

Signature required below.

____

Signature of person making request and relationship if other than the patient

DO NOT COMPLETE - HOSPITAL PERSONNEL ONLY

Date application submitted____________________________ Invoice(s) or Case No_____________.

Received by____

Patient name____

Service date(s)____

Date of birth____

Medicaid applied for and outcome____

INCOME CALCULATION:

TOTAL 3 MONTHS TOTAL 12 MONTHS TOTAL YEARLY INCOME

GRAND TOTAL INCOME FOR HOUSEHOLD:____

Total Bill____

Category applicant qualified for____
(% and household size)

Amount approved____

Remaining balance____

REMARKS

____

Patient Account Representative **Date**