



**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 eligibility determinations. Eligibility determinations are based on the gross (before any deductions) yearly household income and review of assets. Expenses are not taken into consideration. This is not a health insurance plan but rather assistance for unexpected medical expenses.** **You must have outstanding balances with Henry Community Health for your application to be processed.**

1. **Complete this form in its entirety and return to our Central Business office within 10 days. Incomplete applications will result in a denial of your application.**
2. Application approval is based on gross income, family size and assets.
3. **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.**
4. **Two most recent bank statements from all of your checking and savings accounts.**
5. 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.
6. For individuals that are separated, you must report the income the absent spouse contributes to the household.
7. **If you have no income, you must explain how your needs of shelter, food, clothing, etc. are met.**
8. **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. We also need a copy of the POA paperwork to keep with the application.**
9. Your application will be processed within 45 days from the date we receive it back into our office.
10. Once your application is processed you will receive a letter in the mail informing you of the outcome.
11. 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.
12. **Our financial assistance program only applies to Henry Community Health, Henry County Medical Group, New Castle Family and Internal Medicine, Cambridge City Family Health Partners, Knightstown Primary Care, Middletown FHP, 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.**
13. Your application is good for a period of 180 days. After that time a new application is required. If income changes in that 180 day 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: _____ DOB: _____

Address (street): _____ Phone: _____

Do you have health insurance or any other healthcare cost-sharing program? _____

If yes, name of that coverage/program: _____

Have you applied for insurance coverage, including Medicare or Medicaid within the last 90 days? _____

Do you have a checking account? _____ **Two most recent statements are required.

Do you have a savings account? _____ **Two most recent statements are required

WHAT IS THE HOUSEHOLD GROSS INCOME PER MONTH? \$ _____

****PROOF OF INCOME IS REQUIRED TO SUPPORT GROSS INCOME AMOUNT GIVEN.**

Please use the lines below to list everyone living in your household and their individual income or 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.

<u>Name</u>	<u>Relationship to Patient</u>	<u>Age</u>	<u>Employer Name</u>	<u>Gross Income per Month</u>
1. _____				
2. _____				
3. _____				
4. _____				
5. _____				
6. _____				
7. _____				
8. _____				



REQUIRED INCOME TO REPORT

<u>Earnings from Work</u> Wages/salaries/tips Strike benefits Unemployment compensation Workman's compensation Net income from self-owned business or farm	<u>Pensions/Retirement/Social Security</u> Pensions Retirement income Social Security Veteran payments Supplemental Social Security
<u>Welfare/Child Support Alimony</u> Public assistance payments Welfare payments Alimony payments Child support payments	<u>Other Income</u> 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 attest that the information provided above is accurate, true and complete.

Signature required below.

Date:

***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