SCHNECK MEDICAL CENTER
Better Healthcare Begins Here

FINANCIAL ASSISTANCE PROGRAM
APPLICATION FOR FINANCIAL ASSISTANCE

This box to be completed by Schneck Staff
Account Number(s):
Total Outstanding Balance:

*****Print all sections of this application. If a question does not apply to you, indicate by writing "n/a" or "none" in the blank. If you have questions about this form, contact a Financial Counselor at 812-522-0411 x3.**

All fields must be filled in for your application to be considered.

SECTION 1 – PATIENT INFORMATION

Patient Name_____
Last First MI

Social Security #_____-____-_____Date of Birth____/____/_____

Does the patient have health insurance? Yes ☐ No ☐

If YES, Insurance Plan Name _____Policy ID #_____

Is the balance due related to a motor vehicle or work related injury? Yes ☐ No ☐

If YES, Carrier Name _____Carrier Phone #_____

Claim ID_____

SECTION 2 – GUARANTOR INFORMATION (Person responsible for paying the bill)

Guarantor Name_____
Last First MI

Social Security #_____-____-_____Date of Birth____/____/_____

Street Address_____City_____State____Zip_____

Primary Phone #_____Other Phone #_____

Employer Name_____Employer Phone #_____

Employer Street Address_____City_____State_____Zip_____

SECTION 3 – HOUSEHOLD INFORMATION (List all related persons that constitute one taxable unit.)

Name	Age	Relationship to Patient	Employer Name	Other Income (Social Security/ Disability/ Unemployment/ Pension/Child Support/ Alimony/Rental Interest/Other)
1)		Patient		
2)				
3)				
4)				
5)				
6)				

SECTION 4 – SUPPORTING DOCUMENTATION CHECKLIST (Copies of all applicable supporting documentation must be provided for your application to be considered. Documents will ***not*** be returned.)

X	Supporting Documentation
	Last three months' pay stubs for all household earners
	Most recent federal tax return for all family members **(i.e. 1040, 1040A, or 1040EZ, not W-2)**
	Three most recent bank statements (checking, savings, investments, retirement, etc.) for all family members. All bank statements must contain transaction detail.
	Unemployment eligibility or denial letter
	Year to date business records showing allowable IRS income and expense for all self-employment, rental income, and/or farm income
	Legal decree showing tax dependent eligibility and court ordered income
	Statement and contact information from any individuals assisting with living expenses

SECTION 5 – ADDITIONAL COMMENTS

_____

_____

_____

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_____

SECTION 6 – SIGNATURE

I certify that the information provided within the Application for Financial Assistance is an accurate and true representation of my financial information. I authorize Schneck Medical Center to verify the information contained herein, including, but not limited to, employment, social security, government and commercial health insurance coverage. I understand providing false information will result in denial of the application for any type of financial assistance through Schneck Medical Center. My failure to complete the Application for Financial Assistance, including providing supporting documentation, in its entirety within the required timeframe established within Schneck Medical Center's Financial Assistance Policy, will result in denial of financial assistance. I understand that I may be contacted by a Schneck Medical Center representative to discuss my application and may be required to submit additional documentation and/or meet with a Financial Counselor to complete this Application for Financial Assistance and be considered for the financial assistance program. I understand that I am responsible for account balances not covered by or in partial by financial assistance. My signature below grants permission to speak to any party listed on the application for which financial assistance is being considered for.

_____ _____

Patient (Responsible Party) Date

_____ _____

Additional Patient over 18 Date

_____ _____

Additional Patient over 18 Date

Return completed application and copies of supporting documentation to:
Schneck Medical Center
Attn: PFS, Financial Counselor
411 W Tipton St
Seymour IN 47274 or email all documents to customerservice@schneckmed.org