Financial Assistance Application

YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help us determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. 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 it to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care.

If you have any questions or need help completing the application, please call us at 1-866-903-0436.

Mail all documentation to the following address:
Franciscan Alliance
Coordinated Business Office
2434 Interstate Plaza Drive, Suite 2
Hammond, IN 46324

Account Number(s): _____

Instructions: Attach copies of:

- Bonds, Money Market, Stocks
- Tax returns and supporting schedules (previous 2 yrs.)
- If retired, Social Security benefits and any pension
- Business Profit and Loss Statement
- If disabled, verification of benefits
- Pay stubs (most recent 3 months)
- Bank statements (most recent 3 months for all accounts)
- W-2's or Unemployment Statement
- **Note**: You may also provide a written explanation of why you need financial assistance.

I have applied for or will apply for State or Federal Medical Assistance

Yes ☐ No ☐ If No, Reason _____

My injuries are a result of crime victim

Yes ☐ No ☐ If No, Reason _____

I have a lawsuit, settlement, personal injury, or liability claim pending.

Yes ☐ No ☐ If Yes, provide details _____

I have previously applied for financial assistance at another Franciscan Alliance facility.

Yes ☐ No ☐ Not Sure ☐

If Yes, where _____ and when _____

Responsible Party/Patient

Guarantor Name	Patient Name	Patient Social Security Number	Patient Birth Date *(Month DD, YYYY)*

Address

City	State	ZIP Code

Phone	Cell Phone	Family Size *(Patient, Spouse and Dependents)*	Marital Status	Are you claimed on another tax return? Yes No

Student Full-Time Student Part-Time Student	School

Employment Status Full Time Part Time Self Employed Unemployed	Employer Name

Employer Address	Employer Phone

City	State	ZIP Code

Job Title	Employment Length	Unemployed Date/Length *(Month DD, YYYY)*

Spouse

Name	Social Security Number	Birth Date *(Month DD, YYYY)*

School ☐ Full Time Student ☐ Part Time Student	Phone	Cell Phone

Employment Status ☐Full Time ☐Part Time ☐Self Employed ☐Unemployed	Employer Name

Employer Address	Employer Phone

City	State	ZIP Code

Job Title	Employment Length	Unemployed Date/Length *(Month DD, YYYY)*

Dependents(Living at Home/School)

Full Name	Relationship	Birth Date (Month DD, *YYYY)*

Bank Account Balances

Account Type (Checking, Savings	Bank Name	Bank Address	Current Acct. Balance
Other Investments and Securities			
IRA, Retirement, 401K, 403B)			
Money Market, Stocks, Bonds, CDs,			
Cash value of life insurance			

Equity in real estate/properties excluding primary residence

Type	Detail	Estimated Property Value	Unpaid Mortgage Balance
Land			
Homes other than Primary Residence			
Rental Property			
Business Property			
Other			

Family Income

Income Description (list all types that apply)	Source	Monthly Income Amount
Responsible Party/Patient Gross Wages, Salary and Tips		
Spouse Gross Wages, Salary and Tips		
Interest/Dividends, Pension, Social Security, Supplemental Security, Retirement Income		
Unemployment, Public Assistance Compensation, Veteran's Payment, Survivor Benefits		
Royalties, Trusts, Estate Income, Strike Benefits, Lottery/Gaming Winnings		
Disability/Worker's Compensation		
Alimony/Child Support		
Other		

Creditors indicate all other payments, e.g., bank payments, credit cards, other medical, etc.

Type	To Whom	Unpaid Balance	Monthly Payment
Mortgage(s)			
Home Equity Loans			
Personal Loans			
School Loans			
Vehicle Loans			
Credit Cards			
Medical: Doctor Liability			
Medical: Hospital Liability			
Other			

Certification

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me by be reversed, and I will be responsible for the payment of the hospital bill.

Patient/Responsible Party Signature	Date *(Month DD, YYYY)*
Spouse/Partner Signature	Date *(Month DD, YYYY)*

If a patient meets the presumptive eligibility criteria or is otherwise presumptively eligible by virtue of the patient's family income, the patient shall not be required to complete the portions of the application addressing the monthly expense information and estimated expense figures.