HARRISON COUNTY HOSPITAL

An affiliate of NORTON HEALTHCARE

FINANCIAL DOCUMENTATION REQUIRED FOR ALL MEMBERS OF THE HOUSEHOLD

Date:_____

Dear Patient,

In an effort to assist you with your medical expenses at Harrison County Hospital, an application for financial assistance is enclosed. Please **complete the application** and **provide copies** of the documentation checked below.

You may be contacted by a representative from an outside agency (ClaimAid or Complete Billing Services) who work with the hospital, to see if you are eligible for other payment sources that may be available. Failure to cooperate with one of these outside agencies will result in a denial of financial assistance.

For the application to be considered, you MUST return the following documents:
(Your application cannot be processed for consideration if the requested documentation is not included.)

__X__ **Food Stamps or TANF** ****If you provide proof of current eligibility for Food Stamps or TANF you do not need to provide any other documentation other than the proof of eligibility letter and filled out application form.****

__X__ **Federal Tax Return (1040) for the most recent year (or IRS Form 4506-T).**

__X__ **Last Three Months of Financial Information:**
(Checking, Savings and Investments - *please include all pages of each statement*)

__X__ **Pay Stubs for the last 13 weeks for patient and spouse (or last 7 bi-weekly pay stubs), if income has changed since previous year's tax return.**

__X__ **Proof of Any Other Income (i.e. Social Security, Child Support, Rental Income, Unemployment, Pension, Self-Employment, etc.).**

__X__ **Other:** If either you or your spouse have no income then that person must submit a signed personal statement noting the date you last worked and/or the start date of disability and how primary household expenses are paid.

Other: _____

_____

Please return materials **by mail or fax (812) 738-8780** within 10 days or call me **to schedule an appointment to copy and review** the information. If you have any questions, please feel free to call me **at (812) 738-7846**.

Thank you,

Stephanie Lovings
Financial Counselor
1141 Hospital Drive NW • Corydon, IN 47112 • (812) 738-7846 • (800) 447-4251 ext. 2230 • Fax: (812) 738-8780

APPLICATION FOR FINANCIAL ASSISTANCE **ACCOUNT #** _____

I hereby request that Harrison County Hospital make a written determination of my eligibility for financial assistance services. I understand that the information, which I submit concerning my annual income and family size, is subject to verification by this Hospital. I also understand that if the information, which I submit, is determined to be false, such a determination will result in a denial of financial assistance and that I will be liable for charges for services provided.

PLEASE PRINT

1. GUARANTOR ***(person responsible for payment)***

Name: _____ **DOB:** ___/___/___ **Social Security #:** _____
Last First MI

Address: _____ **Phone #(**_____**)**_____
Number and Street City State Zip

County: _____ **Primary Physician:** _____

2. EMPLOYER _____ **OCCUPATION** _____

Address: _____ **Phone #(**_____**)**_____
Number and Street City State Zip

3. PATIENT'S information ***if different than Guarantor***

Name: _____ **DOB:** ___/___/___ **Social Security #:** _____
Last First MI

Address: _____ **Phone #(**_____**)**_____
Number and Street City State Zip

4. PATIENT'S Spouse

Name: _____ **DOB:** ___/___/___ **Social Security #:** _____
Last First MI

Address: _____ **Phone #(**_____**)**_____
Number and Street City State Zip

SPOUSE'S EMPLOYER _____ **OCCUPATION** _____

5. Has guarantor filed bankruptcy in the last 12 months? Yes No

6. FAMILY SIZE _____ **(*All persons claimed on tax return*)**

7. INCOME: List income for all the family members claimed on your tax return. ***Attach proof of the supporting income***

NAME	RELATIONSHIP	AGE	NAME	RELATIONSHIP	AGE
1.			5.		
2.			6.		
3.			7.		
4.			8.		

APPLICATION FOR FINANCIAL ASSISTANCE ***continued***

8. TOTAL AMT. FOR LAST 13 WEEKS

Gross Wage	**$**_____
Self-Employment or Personal	**$**_____
TANF Benefits	**$**_____
Food Stamps Benefits	**$**_____
Social Security/Disability	**$**_____
Unemployment Compensation	**$**_____
Worker's Compensation	**$**_____
Child Support	**$**_____
Pensions	**$**_____
Income from Dividends, Interest, or Rental	**$**_____
Other (Please Explain)	**$**_____

TOTALS $_____

9. ASSETS (please provide copies **for last 3 months)**

$_____**Checking Acct Balance**

Financial Institution Name: _____

$_____ **Saving Acct Balance**

Institution Name: _____

$_____**Investments (Stocks, Bonds, Mutual Funds, Money Market Account(s), CD's)**

$_____**Other Assets (please describe)**

_____

$_____ **TOTAL ASSETS**

FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA *FOR HOSPITAL*

Based upon Federal Poverty Guidelines, Gross income levels, 2024

Family Size	100%	75%
1	0-30,120	30,121-45,180
2	0-40,880	40,881-61,320
3	0-51,640	51,641-77,460
4	0-62,400	62,401-93,600
5	0-73,160	73,161-109,740
6	0-83,920	83,921-125,880
7	0-94,680	94,681-142,020
8	0-105,440	105,441-158,160
Each Additional	10,760	16,140

If you would like a copy of the Financial Assistance Policy go to WWW.HCHIN.ORG or call (812) 738-7846.

AUTHORIZATION TO RELEASE INFORMATION

The undersigned certifies the following:

1. **Patient and/or guardian has applied for financial assistance with Harrison County Hospital and as part of the application process, it is understood that Harrison County Hospital may verify information contained in patient and/ or responsible party's application and in other documents such as the patient's credit report which may have been supplied in connection with the financial assistance application.**

2. **Patient and/or responsible party duly authorize you to release and provide to Harrison County Hospital any and all information and documentation that they may request. I give permission to Harrison County Hospital to discuss any accounts that are in the patient and/or guardian's name.**

3. **A photo or faxed copy of this authorization may be accepted as an original.**

Printed Patient's or Responsible Party Name	**Patient's or Responsible Party Signature**
Social Security Number	**Date**
Printed Spouse/Other's Name	**Spouse/Other's Signature**
Social Security Number	**Date**

I understand that the information which I submit is subject to verification by Hospital. I certify that the above information is true, correct, and complete.