Revised 11/09/16

DEKALB HEALTH
Promote. Preserve. Restore.

Financial Assistance Application

Financial Counselor Phone: 260.920.2618 Fax 260.920.3613

TO BE CONSIDERED FOR FINANCIAL ASSISTANCE, YOU MUST SUPPLY THE FOLLOWING:

You must first attempt to obtain retroactive coverage through governmental medical assistance programs such as Medicaid or HIP (Health Indiana Plan).

1. Verification of all income for everyone in the household.

* Most recent Paystub
* Social Security Benefit Letter
* Unemployment
* Pension
* Child Support

If you have No Income: You must provide us with a brief letter explaining how you provide food, clothing, and housing for your household. If someone is providing these things for you they must sign and date the letter. We will need verification that you are unemployed. Please provide a termination letter from your employer or a work history printout from the unemployment office. If you are not working due to your health please provide a letter from your physician.

2. Your most recent bank statement for all checking and savings accounts.

3. Your most recent Federal tax form (1040).

APPLICANT INFORMATION

Name (First, MI, Last):	
Date of Birth:	**Social Security Number:**
Phone:	**Alternate Phone:**
Current Address:	**City/State/Zip:**
Spouse's Name:	**Spouse's Social Security Number:**

INFORMATION REGARDING ALL MEMBERS OF HOUSEHOLD

Name:	Date of Birth	Relationship	Annual Income	Income Source
		Self	$	
			$	
			$	
			$	
			$	
			$	
			$	
Gross Annual Household income Before Taxes			$	

Important: When calculating your annual income, please include all sources of income such as salary, unemployment, child support, social security and disability, pension, estimated self-employment income, etc.

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ACCOUNT INFORMATION

Patient Name (First, Last)	Account Number	Service Date	Balance
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$

Please provide any further information below that you feel will assist in our determination process:

VERIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE:

I certify under the penalty of perjury that all of the information provided as part of this Financial Assistance application is true and accurate. I understand that the information supplied in this application is subject to verification by DeKalb Health and hereby authorize any holder of information supplied in this application to release such information to DeKalb Health for purposes of this application. I further understand that failure to disclose information requested in this application or disclosure of erroneous information will cause the application to be denied. I also agree to apply for state or federal assistance prior to an award of financial assistance, if applicable. If I am entitled to any action against or settlement from third party payers, I will take any action necessary or requested by DeKalb Health to take such action and will assign to DeKalb Health, all amounts recovered up to the total amount of the outstanding balance on my bill. I hereby authorize DeKalb Health to request a credit check report and/or verify any of the above information as deemed necessary.

SIGNATURE REQUIRED

Applicant's Signature:	**Date:**
Spouse's Signature:	**Date:**

The completed application and verifications should be returned to our Financial Counselor or mailed to:

DeKalb Health
Attn: Financial Counselor
1316 East 7th Street
Auburn, IN 46706