Greene County General Hospital

Financial Assistance Packet

Thank you for allowing us the privilege of serving you and your family! Please complete the following and submit to the Greene County General Hospital Business Office within one month from the date your first statement was mailed to you.

Packet Checklist:

□ Did you completely fill out the application form?

□ Did you attach a copy of your most recent paycheck stub or proof of income?

□ Did you attach a copy of your most recent bank statements: Checking, Savings, and any values of any investments (excludes Retirement Accounts).

□ Did you attach a copy of your most recently filed tax return?

The following things can result in your application being denied:

- Not *completely* filling out the application form
- Not *honestly* filling out the application form
- Not giving us your current phone number so we can contact you if we need more information
- Not submitting this financial assistance packet within above timeframe
- Not submitting the required documents
- Not meeting the financial requirements to qualify for assistance
- Not submitting any additional requested information within above timeframe
- Any application with *no income listed **and** no additional documentation* of how basic necessities are being met

Where do I submit the packet?

- Bring to the Greene County General Hospital Business Office
  - Located across the road from the hospital. Turn at the Hamilton Center; we are the last office building on the right. Hours M-F 8:00 am – 4:30 pm.
- Mail to:
  - Greene County General Hospital
    Attn: Business Office
    1185 North 1000 West
    Linton, IN 47441

How will I know if my application is approved or denied?

- You will receive written notification

Questions? Call Linda Woods at (812) 847 2281 ext 2111

Financial Assistance Application

□ Hospital □ My Clinics □ Both

PATIENT INFORMATION

Name (Last, First, Middle Initial) _____ Date of Birth _____

GUARANTOR INFORMATION *(Person Responsible for the bill)*

Date _____

Name (Last, First, Middle Initial) _____ Social Security Number _____

Street Address, City, State, and Zip Code _____ Relationship to Patient _____

Primary Phone Number _____ Alternate Phone Number _____ E-Mail Address _____

Can you be claimed as a dependent on anyone else's income tax return? □ Yes
□ No

DEPENDENTS *(As listed on your last income tax return. Include spouse.*
List each person separately. List additional on back of form)

Name (Last, First, Middle Initial)	Relationship	Date of Birth (mm/dd/yyyy)	Social Security Number

Financial Assistance Application Continue

EMPLOYMENT and INCOME INFORMATION

Are you employed? □ Yes □ No

If Yes – please attach a pay stub

Where are you employed? _____

When did you start working here? _____

Do you have a 2nd job? □ Yes □ No

If Yes – please attach a pay stub

Where are you employed? _____

When did you start working here? _____

Have you worked anywhere else this current year? □ Yes □ No

If Yes – please attach a pay stub

Where are you employed? _____

When did you start working here? _____

If Yes – please attach a pay stub

Where are you employed? _____

When did you start working here? _____

If you reported $0 income, please provide a brief explanation of how you (or the patient) are meeting basic living needs. Please also provide a letter of support from any individual assisting you.

List other sources of income (for example, social security, disability, pension, unemployment)

Source: _____ Amount: _____

Source: _____ Amount: _____

Do you receive Child Support and/or Alimony? □ Yes □ No

If Yes, how much do you receive each week? _____

Please submit proof with this packet

Financial Assistance Application Continue

ASSETS INFORMATION:

Do you have any Assets? □ Yes □ No

If Yes – please fill out below:

Do you have:	Circle Choice	Description	Total Current Value	Type of Verification Required
Checking Accounts (total balances)	Yes/NO			Most Current bank statement (s)
Savings Accounts (Total balances)	Yes/NO			Most Current bank statement (s)
CD's	Yes/NO			Most Current bank statement (s)
Stocks	Yes/NO			Most Current bank statement (s)
Bonds	Yes/NO			Most Current bank statement (s)
Other	Yes/NO			Documentation

HOUSEHOLD INCOME *(Include all income from all persons living in your house. You must provide yearly proof of income with this form, such as a current pay stub. If submitting before March, your W2 from the previous year will be accepted.)*

_____

Person Employer

_____

Person Employer

_____

Other Income

OTHER INFORMATION

Have you applied for Medicaid? □ Yes □ No

If NO, we will schedule a meeting for you with our Claim Aid Representative

Is there any other party or insurance that may be liable for your medical expenses? □ Yes □ No

If yes, please list the insurance or other liable party:

Financial Assistance Application Continue

STATEMENT

I attest that the information and all statements contained in this Financial Assessment are correct and complete. I authorize Greene County General Hospital to verify any information contained herein. I understand that untrue or incomplete information is cause for denial.

_____ _____

Patient or Responsible Party Date

FOR ADMINISTRATIVE USE ONLY

Date Received: _____

Verification: Pay Stub _____ IRS Form W-2 _____ Form 1040 _____

Employer Statement _____

Other:

_____

_____

Approved_____ Denied _____

_____ _____

Signature of Financial Director Date