Date:

Dear:

Enclosed you will find a "Personal Financial Statement" which will be used to determine if you are eligible for financial assistance. In order for your request for assistance to be processed, you will need to complete and sign the entire form and submit copies of the following items within fifteen (15) calendar days:

- All sources of income for the last three months.
- Copies of most recent paycheck for three months for responsible members of household. This includes disability checks.
- Statements from all bank accounts, certificates of deposit, stocks, bonds, real estate, 401(K), etc.
- Most recent state and federal income tax forms including W2's and Schedules C, D, E and F. If you did not complete a tax form, we need a statement from the IRS showing you did not file a tax form. You can obtain this information by calling the IRS at 800.829.1040.
- If you are not employed we can also accept a statement from the unemployment office stating you are not working and for how long.
- Health Insurance Cards

It is important that you return all of the above items, including the completed and signed Personal Financial Statement. Your request cannot be processed without the above information and you will be subject to the OrthoIndy Hospital Financial Policy. **Your signature is required to obtain the credit report.**

If you have any questions or difficulty in obtaining the necessary information, please call our Patient Financial Services Manager at 317.773.4225.

Sincerely,

Patient Financial Services

ORTHOINDY
MAIN • SOUTH • WEST • HOSPITALS

Financial Statement
Personal Information

Patient Account Number: ______________________ Return By: ______________________

The Personal Financial Statement **must** be completed and returned in the self-addressed envelope within 10 working days. **You will need to attach three months of current pay stubs and/or social security verification as well as the current year's tax return for income verification.**

If the Personal Financial Statement is not complete, and/or requested information is not supplied, assistance will not be considered.

Patient Information

Patient's Name: ______________________ Account Number: ______________________

Guarantor's Name: ______________________ Phone Number: ______________________

Address: ______________________ ☐ Rent ☐ Own SSN: ______________________

______________________ Social Security Number: ______________________

Marital Status: ______________________ Number of Dependents: ______________________

Dependent: ______________ Ages: ______ Dependent: ______________ Ages: ______

Dependent: ______________ Ages: ______ Dependent: ______________ Ages: ______

Dependent: ______________ Ages: ______ Dependent: ______________ Ages: ______

Employment

Guarantor's Employer: ______________________ Years Employed: ______

Address: ______________________

Salary: __________ Per: ☐ Week ☐ Month ☐ Year Job Title: ______________________

Guarantor's Employer: ______________________ Years Employed: ______

Address: ______________________

Salary: __________ Per: ☐ Week ☐ Month ☐ Year Job Title: ______________________

Spouse's Employer: ______________________ Years Employed: ______

Address: ______________________

Salary: __________ Per: ☐ Week ☐ Month ☐ Year Job Title: ______________________

Other Monthly Income *(check those that apply)*:

☐ SSI, $______________________ ☐ Retirement: $______________________

☐ ADC: $______________________ ☐ Child Support: $______________________

☐ Unemployment: $______________________ ☐ VA Benefits:$______________________

☐ Other: ______________________ Food Stamps: ☐ Yes ☐ No

Insurance Information

Do you have insurance to pay hospital charges? ☐ Yes ☐ No

Have you applied for Medicaid? ☐ Yes ☐ No Approved? ☐ Yes ☐ No ☐ Rejected

Caseworker Name: ______________________ Phone Number: ______________________

Name of Primary Insurance: ______________________ Policy Number: ______________________

Name of Policy Holder: ______________________ Effective Date: ______ /______ /______

Name of Secondary Insurance: ______________________ Policy Number: ______________________

Name of Policy Holder: ______________________ Effective Date: ______ /______ /______

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Financial Statement
Assets

Patient Account Number: ______________________ Return By: ______________________

Assets

Checking Account No.: ______________ Bank: ______________ Balance: __________
Address: ______________________

Savings Account No.: ______________ Bank: ______________ Balance: __________
Address: ______________________

Other Assets

Check those that apply: ☐ CD's ☐ Savings Bonds ☐ Stock ☐ Trust Funds ☐ Other

Financial Institution: ______________________ Total Worth: ______________
Financial Institution: ______________________ Total Worth: ______________
Financial Institution: ______________________ Total Worth: ______________

Real Estate/Home

Estimated Value of Home: ______________________ Mortgage Balance: ______________
(The amount you expect from the sale of your home.)

I hereby certify that the answers given to the above questions are correct and true to the best of my knowledge.

Signature: ______________________ Date: ______ /______ /______

Additional information my be listed below and additional pages if needed:

____

____

____

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Should you have any questions concerning any of the information that has been requested, please call **317.773.4225**.

I hereby give permission to OrthoIndy Hospital to obtain a credit report on me and my spouse:

Signature: ______________________ Date: ______ /______ /______

Signature and all applicable information required to proceed with the application process.