

ORTHOINDY HOSPITAL

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

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
 Social Security Number: _____
 Marital Status: Single Married Divorced Widowed Number of Dependents: _____
 Dependent: _____ Age: _____ Dependent: _____ Age: _____
 Dependent: _____ Age: _____ Dependent: _____ Age: _____
 Dependent: _____ Age: _____ Dependent: _____ Age: _____

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: _____ / _____ / _____

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 Stocks 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 may be listed below and on additional pages, if needed.

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.