This box to be completed by Schneck Staff

Account Number(s):

Total Outstanding Balance:

***Print all sections of this application. If a question does not apply to you, indicate by writing "n/a" or "none" in the blank. If you have questions about this form, contact a Financial Counselor at 812-522-0411 x3.

All fields must be filled in for your application to be considered.

SECTION 1 – PATIENT INFORMATION

Patient Name				
Last	First		MI	
Social Security #Date of Birth	_//			
Does the patient have health insurance? Yes 🔲 No				
If YES, Insurance Plan Name	Polic	cy ID #		
Is the balance due related to a motor vehicle or work r	elated injury? Yes 🔲	No 🗖		
If YES, Carrier Name	Carrier Pho	one #		
Claim ID				
SECTION 2 – GUARANTOR INFORMATION (Person responsible for paying the bill)				
Guarantor Name				
Last	First		MI	
Social Security #Date of Birth	//			
Street Address	City	State	Zip	
Primary Phone #	_Other Phone #			
Employer Name	Employer Phor	e #		
Employer Street Address	City	State	Zip	

SECTION 3 – HOUSEHOLD INFORMATION (List all related persons that constitute one taxable unit.)

Name	Age	Relationship to Patient	Employer Name	Other Income (Social Security/ Disability/ Unemployment/ Pension/Child Support/ Alimony/Rental Interest/Other)
1)		Patient		
2)				
3)				
4)				
5)				
6)				

SECTION 4 – SUPPORTING DOCUMENTATION CHECKLIST (Copies of all applicable supporting documentation must be provided for your application to be considered. Documents will *not* be returned.)

X	Supporting Documentation
	Last three months' pay stubs for all household earners
	Most recent federal tax return for all family members (i.e. 1040, 1040A, or 1040EZ, not W-2)
	Three most recent bank statements (checking, savings, investments, retirement, etc.) for all
	family members. All bank statements must contain transaction detail.
	Unemployment eligibility or denial letter
	Year to date business records showing allowable IRS income and expense for all self-
	employment, rental income, and/or farm income
	Legal decree showing tax dependent eligibility and court ordered income
	Statement and contact information from any individuals assisting with living expenses

SECTION 5 - P	ASSETS (Please	circle and docu	iment on items	s which apply to you)	
Bank Account	t (s): Checking	g Account, Aver	age Value \$, Savings Account, Average Value \$	
Housing:	Own	Rent	Homeless	Other	
Vehicle:	Own	Lease	None	Other	
Retirement A	ccount: Yes	or No	If yes, Type	& Current Value \$	
SECTION 6 – ADDITIONAL COMMENTS					

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SECTION 7 – SIGNATURE

I certify that the information provided within the Application for Financial Assistance is an accurate and true representation of my financial information. I authorize Schneck Medical Center to verify the information contained herein, including, but not limited to, employment, social security, government and commercial health insurance coverage. I understand providing false information will result in denial of the application for any type of financial assistance through Schneck Medical Center. My failure to complete the Application for Financial Assistance, including providing supporting documentation, in its entirety within the required timeframe established within Schneck Medical Center's Financial Assistance Policy, will result in denial of financial assistance. I understand that I may be contacted by a Schneck Medical Center representative to discuss my application and may be required to submit additional documentation and/or meet with a Financial Counselor to complete this Application for Financial Assistance and be considered for the financial assistance program. I understand that I am responsible for account balances not covered by or in partial by financial assistance. My signature below grants permission to speak to any party listed on the application for which financial assistance is being considered for.

Patient (Responsible Party)	Date
Additional Patient over 18	Date
Additional Patient over 18	Date
Return completed application and copies of supporting documentation Schneck Medical Center Attn: PFS, Financial Counselor 411 W Tipton St Seymour IN 47274 Or Email all documents to customerservice@schneckmed.org	to:

Application for Financial Assistance