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, write "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 along with ALL supporting documents in the section 4 checklist

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 _____Policy ID #_____

Is the balance due related to a motor vehicle or work related injury? Yes ☐ No ☐

If YES, Carrier Name _____Carrier Phone #_____

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 Phone #_____

Employer Street Address_____City_____State_____Zip_____

SECTION 3 – HOUSEHOLD INFORMATION (List all persons living in your household)

Name	Date of Birth	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 pay stubs for all household earners, social security award letter and pension documentation if applicable.
	The most recent bank statements (checking and savings) 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.
	Statement and contact information from any individuals assisting with living expenses.

SECTION 5 – ADDITIONAL COMMENTS

_____

_____

SECTION 6 – SIGNATURE
****Please note ALL household members over 18 must sign the application****

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.

_____ _____
Patient (Responsible Party) Date

_____ _____
Additional Household Member over 18 Date

_____ _____
Additional Household Member over 18 Date

Return completed application and copies of supporting documentation to:
Schneck Medical Center
Attn: PFS, Financial Counselor
411 W Tipton St
Seymour IN 47274