Community Rehabilitation Hospital South

APPLICATION FOR FINANCIAL ASSISTANCE

Thank you for giving us the opportunity to serve your healthcare needs and for expressing interest in our Financial Assistance Program.

Please complete this application and return it along with **all supplemental documentation required within 15 days** to avoid possible denial of your application. The information you provide will be held in strict confidence and will not be used for any purpose other than to assess your need for financial assistance. We will not share this information with any person or organization outside of Community Rehabilitation Hospital.

Please provide the following information completely and accurately. Information is subject to verification. Please attach a list of additional household members if there are more than five (5) members.		
Patient Name (First, MI, Last)	SSN	Total # of household members
Address	Date of Birth	Home/Cell Phone
City/State/ZIP		Work Phone
Guarantor Name	Account #	

Dependents may live outside of your primary household residence if they are claimed on your or your spouse's tax return.

List ALL household member names	Date of Birth	SSN	Relationship to Patient	Insurance
1		- -		Yes / No
2		- -		Yes / No
3		- -		Yes / No
4		- -		Yes / No
5		- -		Yes / No

Monthly Budget

Gross Monthly Income (GMI)		**Transportation:**	
Source:	$	Gas & Oil	
Source:	$	Total	$ _____
Source:	$	**Medical/Health:**	
Source:	$	Current Bills	$ _____
Source:	$	Medications	$ _____
Total	$ _____	Total	$ _____
Monthly Expenses		**Insurance:**	
Housing:		Auto Insurance	$
Mortgage/Rent	$	Health Insurance	$
Total	$ _____	Homeowners/Renter Insurance	$
Utilities:	$	Life Insurance	$
Electricity/Gas/Water	$	Total	$ _____
Internet/Cable	$	**Debts:**	
Phone/Mobile	$	Car Payment(s)	$
Trash	$	Child Care	$
Total	$ _____	Credit Card(s)	$
Food:		Student Loans	$
Groceries	$	Other	$
Total	$ _____	Total	$ _____
		Total Expenses	**$** _____

I CERTIFY that the information I have provided is a true and accurate representation of my family size and household income. I understand that any misrepresentation of this information will result in denial of financial assistance. I authorize Community to access additional sources of information to verify my qualification for assistance.

Applicant/Patient Signature _____ Date _____

Spouse Signature (if co-applicant) _____ Date _____

Thank you for your application and for the opportunity you have given us to serve your health care needs. Please return your completed application and all supporting documentation to: **Fax Number: 636.730.3127, or U.S. Mail Address: 607 Greenwood Springs Drive, Greenwood, IN 46143 . Please call 317.215.3804** if you have any questions or need assistance with this application. **We will notify you of our decision within 45 days of the receipt of your application.**

Community Rehabilitation Hospital South

FAP DOCUMENT CHECKLIST

Please send a signed statement explaining if there is anything that you cannot provide.

Application:

- ☐ Completed application for financial assistance

Proof of Gross (pre-tax) Income – For all household members:

- ☐ The *last 3 pay stubs* for all employed household members (i.e. Wages, Salaries, Tips, Commissions, etc.)
- ☐ Proof of pensions, retirement, unemployment or disability benefits. This is needed at least once per year
- ☐ Child Support/alimony
- ☐ Social Security award letter. – *Your bank statement does not always show the gross amount.*
  - (Call 1.800.772.1213 for replacement)

Taxes:

- ☐ Most recent year's "Complete" **Federal** tax return that you were claimed on. (If you do not have your tax return, you can visit www.irs.gov or call 317-685-7500 to order a "tax return transcript"). State taxes and W-2s are not acceptable.
  - If you do not file taxes, or are a legally documented alien, please provide a copy of your social security card and/or proof of citizenship status.

Bank Statements:

- ☐ Last three months of complete bank statements for all accounts (including business accounts)
  - For the bank statements, "Complete" means that if the statement says, "page 1 of 6," ALL 6 pages are needed, even if some of them are intentionally left blank. *Account Summaries or Transaction Histories are not acceptable.*

Residency (if claiming no income):

- ☐ Statement of support from person(s) providing room and board with his/her name, address and what is being provided
- ☐ Current homeless shelter residency verification