



Good Samaritan

Central Billing Office

APPLICATION FOR FINANCIAL ASSISTANCE

Thank you for choosing Good Samaritan for your healthcare needs. Financial assistance is available to individuals who qualify, whether treatment was provided at the hospital or at one of our Good Samaritan outpatient clinics. Good Samaritan makes it easy to apply for such financial assistance.

Please complete this application to the best of your ability and as fully as possible and return it, along with the information to verify income, within 15 days. This will help us answer your request as quickly as possible. If you would like to provide additional information of any kind that you feel will help us better understand your situation, please attach a letter to this application.

Failure to complete this application and submit all the necessary documentation to verify income will result in a denial of your application.

PATIENT/GUARANTOR NAME _____ DATE OF BIRTH _____ *SSN _____

STREET ADDRESS _____ CITY, STATE _____

PHONE# _____ ACCOUNT # _____

SPOUSE'S NAME _____ DATE OF BIRTH _____ *SSN _____
*SSN will not be used to determine eligibility

A. DEPENDENTS (Anyone under age 18 living in the household)

| Name | Age | Relation | Name | Age | Relation |
|------|-----|----------|------|-----|----------|
| 1. | | | 5. | | |
| 2. | | | 6. | | |
| 3. | | | 7. | | |
| 4. | | | 8. | | |

B. Is any member of the family covered by health insurance? Yes or No

* C, D and E are informational only; the responses to these questions will not be taken into account to determine eligibility for a discount.

C. * Is any member of the family covered by a medical cost sharing program (i.e. Christian Healthcare Ministries, Medishare, etc)? Yes or No

D. * Is any member of the family a part of the Amish Community contract? Yes or No

E. * Have you applied for Medicaid benefits? Yes or No If yes, date applied: _____

F. Please provide household income:

| | |
|---|---|
| Name of person working _____ | Name of person working _____ |
| Employer _____ | Employer _____ |
| Start date _____ End date _____ | Start date _____ End date _____ |
| Amount of gross pay per period _____ | Amount of gross pay per period _____ |
| How often paid? _____ Hours worked a week _____ | How often paid? _____ Hours worked a week _____ |
| Do hours vary? Yes or No | Do hours vary? Yes or No |
| Is person self-employed? Yes or No | Is person self-employed? Yes or No |

G. Additional sources of income - documentation must be provided:

| | |
|---------------------------------------|----|
| Social Security income | \$ |
| Unemployment income | \$ |
| Pension | \$ |
| Veteran's payments | \$ |
| Income from estates and trusts | \$ |
| Interest, dividends, rents, royalties | \$ |

| | |
|------------------------------|----|
| Child support and/or alimony | \$ |
| Workers compensation | \$ |
| Retirement | \$ |
| Public assistance | \$ |
| Property income | \$ |
| Other income | \$ |

H. Monthly household expenses – list the amount you pay monthly:

| | |
|--------------------|----|
| House payment/rent | \$ |
| House insurance | \$ |
| Car payment | \$ |
| Car insurance | \$ |
| Life insurance | \$ |
| Utilities | \$ |

| | |
|---------------|----|
| Credit cards | \$ |
| Loans | \$ |
| Medical bills | \$ |
| Gasoline | \$ |
| Groceries | \$ |
| Misc. | \$ |

I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.

Signature of patient or guarantor

Date

Signature of spouse

Date

The following information MUST be returned with the completed and signed Financial Assistance Application in order for financial assistance to be processed. **Please do NOT send original documents.**

****IF YOU ARE UNABLE TO PROVIDE TAX OR BANK INFORMATION YOU MUST SUBMIT A SIGNED EXPLANATION.**

Please provide all that applies to you:

- Verification of housing assistance/TANF/food stamps
- Previous year's 1040 federal tax form (ALL SCHEDULED ATTACHMENTS, W-2s CANNOT BE ACCEPTED). If you do not have a copy of your taxes you can visit www.irs.gov or call 317-685-7500 to order a "tax return transcript."
- Copy of award letter for Social Security/SSI/Disability. Call 800-772-1213 for a copy.
- Pension/retirement/unemployment/worker's comp verification
- Year to date paycheck stub FOR LAST 30 DAYS or current income statement from employer. If you have no income, you are required to sign a Work One release for a wage transcript, which is provided by this office. Also, if you are unemployed you must provide a statement from the person who is helping you financially. If no one is helping you, please provide a letter of hardship explaining your current living situation with no income.
- Proof of child support (received or paid)
- To verify income we need a complete bank statement for checking/savings accounts for the past 30 days. ATM receipts and screenshots of accounts cannot be accepted. THE INFORMATION MUST INCLUDE IDENTIFYING INFORMATION (CANNOT BE HANDWRITTEN). Please include ALL pages of the bank statement, including all deposits and withdrawals. If your bank statement shows transactions with an account that does not belong to you or your spouse, you must provide a statement from the bank institution to verify this information.
- Medicine receipts for the last 60 days (printout from pharmacy)
- Proof of payment of health insurance
- Copy of divorce decree or documentation of legal separation, if applicable (divorce decree if divorced within the past year)
- If you are recently unemployed or temporarily laid off, please provide a statement from your employer that supports that information.

Failure to comply will result in denial of your application.

This information should be returned to:
Good Samaritan Hospital Central Billing Office
1160 E. St. Clair St., Vincennes, IN 47591
E-mail: swright@gshvin.org
Phone: 812-885-3340 Fax: 812-885-3917

**** PLEASE NOTE: CO-PAYS MAY BE INCLUDED IF GOOD SAMARITAN'S CONTRACT WITH THIRD PARTY INSURANCE CARRIERS ALLOWS FINANCIAL ASSISTANCE TO BE APPLIED TO CO-PAYS.**

Financial assistance will be applied to accounts for which the first billing statement was sent within 240 days of the date assistance is requested and is valid for six months. We will then review your information and determine your eligibility for the remainder of the calendar year.

Financial assistance applies only to the services that the patient has received from Good Samaritan, Physician Network and Samaritan Center. You may be billed directly from other affiliated providers' billing offices (ex. Midwest Emergency Medicine, Clinical Radiologists, Apogee Physicians, Reginald Sandy, MD, Tri-State Orthopaedics, etc.) and our financial assistance does not apply to those bills. You must contact that billing agency and make arrangements for financial assistance.

FOR OFFICE USE ONLY

Application taken by: _____ Date: _____

