

Pulaski Memorial Hospital
Patient Financial Services

APPLICATION FOR FINANCIAL ASSISTANCE

Helpful Information:

Verification of all income – we must have complete, current information regarding all household income to process your request.

The most commonly acceptable verification of income is listed below. If you do not feel any of these apply to your situation, please contact us; Financial Counselor: 574-946-2106 or Patient Accounts 574-946-2125.

- **If Employed** – 3 most recent paycheck stubs for each wage-earner in the household for each job.
- **Self-Employed** – Please provide verification of gross income from your business for the past 3 years Federal taxes and related schedules. If you draw a regular amount from your business for living expenses, you may also provide a copy of those checks.
- **Receiving unemployment** – we need a copy of your latest unemployment check to verify weekly income and weeks remaining.
- **If you are not currently working** – we need a brief description of your current situation that includes the reason you are not working, and your expected return to work date if applicable. Some common descriptions include homemaker, student, looking for work, or temporarily unable to work with reason (recovering from illness or injury, filed for disability, etc.) **If you list no income on your financial statement form, please include a description of how you are handling your basic living and expenses with no income.**
- **SSD, SSI or Trust or Retirement** – we will need a copy of your most recent monthly payment (can be a check copy or a copy of your bank statement showing the direct deposit amount. If you are on SSD or SSI a copy of your most recent benefits statement is also required.
- **Other income** – appropriate documentation to verify the monthly amount and type of income.

Prior Year Tax Return – We require a copy of your complete, filed Federal tax return from the prior year. This includes copies of all related W-2s, schedules, and 1099 forms used to file the return. If you are not required to file, we require written confirmation of this with the reason. We will still need copies of your W-2 forms, 1099 forms or other information showing your total income for prior year even if you were not required to file a return.

Bank Statements- We require a copy of your most recent 30 day bank statement or statements.

Marketplace Exchanges (HealthCare.gov)/Healthy Indiana Plan (HIP)/Medicaid eligibility – Per the Patient Protection and Affordable Care Act (Public Law 111 – 148, signed on March 23, 2010 / HR 3590 / Sec 1501: effective January 1, 2014, self-pay patients must demonstrate and provide documentation that they have applied for health insurance through one of the Marketplace Exchanges, the Healthy Indiana Plan (HIP) insurance, Medicaid, or other State programs. Sec 2702 of the PPACA provides for Guaranteed Availability of Coverage. If you have been denied, you must provide documentation that denial was for reasons other than failure to complete and follow-through of the application process. A copy of the disposition is required.

If you have been approved for any of the Marketplace health insurances, Hip, or Medicaid please provide a copy of your card or letter showing the effective date. Any open accounts that are within the dates you are eligible will be billed to your Exchange Account/HIP/Medicaid and we will process your application on any accounts that are not eligible and have not gone to collections or other bad debt.

PLEASE NOTE: See page 3 of this packet – if you have applied for Medicaid in a neighboring state and have not received your determination letter yet; please indicate your date of application and the State/County in which you applied.

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Signed Application for Assistance form - Please sign, date and return page 3 of this packet, along with the completed Financial Statement form (page 4) and all other required information. Please keep copies for your records. If you have not enclosed your HIP/Medicaid denial letter, make sure your date and county of application are completed. (Per hospital Financial Assistance policy, *all other sources of payment must be exhausted i.e.: Medicaid, HIP, etc.* Financial assistance requests cannot be completed until such time you have completed the HIP application process and have notification of approval or denial. This may necessitate payments on your account until your HIP application process has completed.)

Completing your Financial Statement Form:

1. Please be sure to complete all areas of the Financial Statement form – even if you put “none, “\$0” or “N/A”. This way we are sure you reviewed and completed the entire form.
2. If you do own property, be sure to include the current market/cash value as well as any loan balance outstanding against the item. This does include rental property and land owned other than your primary residence.
3. We will not request current cash value of your primary vehicles, but will need the loan balance and monthly payment. Also, we may ask for a value and loan balance on any recreational vehicles listed.
4. Retirement accounts such as IRA and 401K accounts should be listed as an asset with the current cash value (meaning the value if you cashed the account in today)>
5. If you have listed dependents on your Financial Statement, and they are not shown as dependents on your prior year’s tax return, please provide detail and verification of the dependent for the current year.
6. Please be sure to list all monthly expenses, even if you are not currently able to make the payment as this information is also used to set up appropriate payment arrangements after your application is processed.
7. Please keep a copy of the information you have provided for your records.

This application is for Pulaski Memorial Hospital and Pulaski Associate Medical Professionals (listed on top of page 3 of this packet), and do not include related billings you may have with, Indiana Emergency Care, CCI Anesthesia , and/or South Bend Medical Foundation (pathology)

Please complete and return all information within 10 days of statement for consideration. Failure to return within 10 days may result in ineligibility for financial assistance. **If you have not yet received your Marketplace Exchange Insurance/HIP/Medicaid denial/approval letter, please return all other required information with your application date to:**

Pulaski Memorial Hospital
Attn: Financial Counselor
P.O. Box 279
Winamac, IN 46996
574-946-2106
Pulaski Memorial Hospital

Patient Financial Services

APPLICATION FOR FINANCIAL ASSISTANCE

Pulaski Memorial Hospital, Pulaski Memorial Medical and Surgical Group, InPatient Care Group (ICG)

In order to review your application, the following documents are required. If you are not able to provide one or more, please include a detailed explanation for our review:

- | | | |
|----|--|---|
| 1. | Verification of all household income. | |
| 2. | Copy of complete tax return and W-2s from all household members | |
| 3. | Healthy Indiana Plan (HIP)/Medicaid denial letter or acceptable verification that you are not eligible in your state of residence. | |
| 4. | Completed Financial Statement form | TOTAL INCOME ON LAST YEAR'S TAXES: \$ _____ |
| 5. | Signed "Application for Financial Assistance" form | NUMBER OF DEPENDENTS: _____ |

PLEASE NOTE: In order to assure your application is processed, as timely as possible, it is very important that we receive all required documentation. The additional pages included in this packet will assist you in understanding each of the requirements.

Please read the following statement, and sign and date below. Your application will not be reviewed until this signed statement and all above information is received.

I acknowledge that I have been given a copy of the Pulaski Memorial Hospital and Pulaski Associates Medical Professionals Financial Assistance Packet. I declare that the information I have provided is true, correct and complete and that I have not omitted any income or property. I understand that failure to fully disclose income or property can result in denial of the financial assistance provided. I understand that in the event I have been granted financial assistance based on incomplete or inaccurate information provided by me or someone on my behalf, Pulaski Memorial and Pulaski Associates Medical Professionals reserves the right to request repayment of the financial assistance amount(s) granted.

Guarantor Signature Date

Guarantor Printed Name

Healthy Indiana Plan (HIP) or Medicaid Application Conformation

If you have applied for HIP/Medicaid and have not received your determination yet, please indicate the date and state/county of application below. Please disregard if you are sending your HIP/Medicaid approval/denial letter with your application.

Date of Application State/County of Application

HOSPITAL USE ONLY:

ACCOUNT #	
SERVICE DATE:	
ACCOUNT BALANCE:	
PAYMENTS MADE:	
DATE SENT:	
DATE TO BE RETURNED BY:	
DATE RECEIVED BACK:	

Pulaski Memorial Hospital
Patient Financial Services
FINANCIAL STATEMENT

Patient's Name: _____
Social Security #: _____
Name of Spouse: _____
(Spouse)

Date of Birth _____
Account Number(s): _____

If Minor Child, Name of Father and Mother or Guardian: _____
(Father and Mother or Guardian)

Address: _____ **Phone:** _____

Do you have insurance that will cover any or all of the charges your date(s) of service? Yes ___ No ___
 Do you have pending litigation that would result in payment of balances if favorable decision? Yes ___ No ___
 Have you completed a Pulaski Memorial Hospital **REQUEST FOR DETERMINATION OF ELIGIBILITY FOR FINANCIAL ASSISTANCE**
 Application within the last 90 days? Yes ___ No ___ 12 months? Yes ___ No ___

Patient's Employer: _____ **\$** _____
 (Monthly Gross Income; incl. Tips)

Spouse's Employer: _____ **\$** _____
 (Monthly Gross Income; incl. Tips)

If Minor Child, Employer of Father and Mother or Guardian: _____ **\$** _____
 (Monthly Gross Income; incl. Tips)

Other Income (Social Security, Retirement/Pension/Trust, Unemployment, Alimony, Child Support, etc.) **\$** _____

Number and Age of Children Living in the Home: _____
 Have you applied for other aid? Please list: _____
 (Example: Medicaid, TANF, Food Stamps, Other)

ASSETS

Financial	Name of Bank: _____	CDs/Stocks/Bonds: \$ _____
	Total Savings: \$ _____	Balance in Checking: \$ _____
Real Estate	Do you own your home: _____	Balance owed: \$ _____
	Market Value: \$ _____	Payment: \$ _____
	Do you own rental property? _____	Income per month: \$ _____
	Do you own acreage? _____	Market Value: \$ _____
Personal Property	Car or truck Make/Model: _____	Year: _____
	Car or Truck Make/Model: _____	Year: _____
	Recreational Vehicle: _____	Year: _____
	Boat: _____	Year: _____
	Farm Machinery: _____	Year: _____
	Livestock (Cattle, Horses, Pigs, etc) Number: _____	

MONTHLY EXPENSES

Rent/Mortgage: \$ _____	All Utilities: \$ _____	Telephone: Cell/Landline: \$ _____ / \$ _____
Food: \$ _____	Gas (Autos): \$ _____	Insurance: \$ _____

Loan: (Type/Lender) _____	Balance: \$ _____	Payment: \$ _____
Loan: (Type/Lender) _____	Balance: \$ _____	Payment: \$ _____

Credit Card: _____	Balance: \$ _____	Payment: \$ _____
Credit Card: _____	Balance: \$ _____	Payment: \$ _____

OUTSTANDING MEDICAL EXPENSES

1. _____	Balance: \$ _____	Payment: \$ _____
2. _____	Balance: \$ _____	Payment: \$ _____
3. _____	Balance: \$ _____	Payment: \$ _____

Please record additional assets, monthly expenses, and medical expenses on the reverse side of this form.
Please make sure all required financial documents are attached: Copy of last year's Federal Taxes, copy of last 3 pay stubs, copy of W-2/1099 forms, copy of Social Security Benefits statement (or bank statement if direct deposit), copy of Unemployment benefits, other.

Date Completed: _____ Daytime Phone: _____

Signature: _____ Print Name of Patient: _____