FINANCIAL ASSISTANCE APPLICATION

Hancock Physician Network

Patient: _____ Account number: _____

HPN Physician:_____ Account balance: $_____

In accordance with the mission and values of Hancock Physician Network, we are providing this application to do an assessment to determine if Financial Assistance may be available for this balance. Please complete and return this application with all requested documents listed on the second page to our billing office, located at **156 W. One Memorial Sq, Ste 50, Greenfield, IN 46140**.

Completed application MUST be returned NO LATER than_____.

PLEASE NOTE: INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED.

Total members in household (this includes everyone living with you at your address): _____

Self: _____ DOB:_____

Name: _____ DOB:_____ Relationship:_____

Name: _____ DOB:_____ Relationship:_____

Name: _____ DOB:_____ Relationship:_____

Name: _____ DOB:_____ Relationship:_____

Do you have insurance coverage?:
☐ YES ☐ NO | If "YES," Please list insurance company:_____

Have you applied for insurance in the Health Insurance Marketplace under the Affordable Care Act?:
☐ YES ☐ NO

Have you applied for Public Assistance?:
☐ YES ☐ NO | If "YES:" ☐ Medicaid ☐ Food Stamps

ANNUAL GROSS HOUSEHOLD INCOME: $_____.

Monthly Income:

Responsible party: $ _____ Spouse: $_____ Total monthly income: $ _____

Child support: $_____ Disability: $ _____ Social Security: $ _____

Other: $ _____

Monthly Expenses:

Mortgage/rent: $ _____ Utilities: $ _____ Food: $ _____

Childcare: $ _____ Auto expenses: $ _____ Credit cards: $_____

Medical bills: $_____ Pharmacy bills: $ _____ Insurance: $ _____

Other: $ _____

PLEASE INCLUDE A COPY OF THE FOLLOWING FOR YOUR APPLICATION TO BE CONSIDERED:

1. Proof of Income: Pay stubs or employer statement documenting wages for three (3) months prior to application.
2. Prior year's income tax return including W-2 forms.
3. Two (2) most recent detailed bank statement: Checking, Savings and any other investments.
4. Copy of Social Security letter (if applicable)
5. Public Assistance approval or denial letter (if applicable)
6. Copy of any other medical bills.

I attest the above information and all income documentation provided is complete and accurate as shown. I realize that should, at any time this information proves to be false, all Financial Assistance given will be reversed, and I will accept responsibility for full and immediate payment of the balance.

By applying for Financial Assistance, I also agree to accept payment responsibility for any amounts due from me as a result of any partial assistance granted. If I do not pay my part, the financial write-off will be reversed and I will be responsible for the full balance.

I hereby authorize Hancock Physician Network to release financial information obtained from their assistance programs to Hancock Regional Hospital and Jane Pauley Center.

Signature: ____ Date: ______________________

Relationship to patient: ____

NETWORK USE ONLY

Patient account rep.:______________________________Doctor office: ___________________________

☐ Denied | Reason for denial: ____

☐ Denied pending more information | information needed: __________________________________

☐ Approved | Percentage:_______________ Effective date: ________________ Term date:_________________

Reviewed: ____ Date: ______________________