Hancock
Regional Hospital

Exhibit A

Hancock Regional Hospital Financial Assistance Application

Financial assistance is available for those that do not have insurance, are underinsured, or if it would be a financial hardship to pay for the expected out of pocket expenses for services rendered by any department of Hancock Regional Hospital.

The application process involves filling out the following financial application form. The Financial Application can be submitted to the Financial Counselors at the following address.

Hancock Regional Hospital
Attn: Financial Counselor
801 N State Street
Greenfield, IN 46140

Please be advised that once we receive your application, additional information may be requested. You will have 30 days to submit the additional information.

In completing the application, there are a few things to consider.

1. When listing household members, only list those that can be claimed on your tax return.
2. Gross Income is all household members that can be claimed on your tax return.
3. Medical bills are to include bills from all providers that are owed for all household members that can be claimed on your tax return.
4. Pharmacy expenses are for all household members that can be claimed on your tax return.
5. Include Health Insurance Premiums paid for insurance if that is applicable.

Hancock Regional Hospital

FINANCIAL ASSISTANCE APPLICATION

Exhibit A

MR Number & Account Number to be completed by hospital personnel	*COUNTY*	*Hospital*	*Account Number:*

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's name (first, MI, Last)	Date of Birth::	Total # Household Members
Address:	Phone numbers: Home: ( ) Work: ( )	
City, ST ZIP:	Responsible if not patient:	

List ALL household member names	**Date of Birth**	**Relation to Patient**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Monthly Income		**Monthly Expenses**	
Responsible Party's Gross Income (before taxes)	$	Rent or own	
Other Household Gross Income (before taxes)	$	Medical Bills	$
Investment Income (Annuities/Stocks/Dividends)	$	Make and model of Car	
Child Support/Alimony Received	$	1st –year/make/model	
Rental Property Income	$	2nd –year/make/model	
Pension/Retirement/Unemployment	$	Pharmacy Expenses	$
Other:	$	Health Insurance Costs	$
Food Stamps (Yes/No)	$	Other	$
Total Monthly Income (before taxes)	$	**Total Monthly Expenses**	$
Assets		Comments:	
Checking Account Balance	$		
Savings Account Balance	$		
Other:	$		

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at time of registration. I understand that providing false information will result in denial of the application for any type of financial assistance through Hancock Regional Hospital. If I am entitled to any action against or settlement from third party payers, I will take any action necessary or requested by Hancock Regional to obtain such assistance and will assign to Hancock Regional, and upon receipt will pay to Hancock Regional, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by Hancock Regional will result in the denial of this application. I also authorize Hancock Regional to check my credit history through the credit bureau, if deemed appropriate.

I also authorize Release of Information from the Division of Family Resources to Hancock Regional Hospital Social Services/Patient Financial Services regarding application approval/denial for Food Stamps and/or Hoosier Healthwise/Medicaid.

Signature of Patient/Responsible Party

Date