The Jane Pauley Community Health Center

Financial Assistance Application

Section A: Patient Information					
Patient Name:				DOB:	SS#:
Address:		Apt:		City:	
State:	Zip Code:	Telephone #:			
Email Address:					
If patient is a minor are you their legal guardian? ____Yes ____No					
Legal guardian name:					

Does the patient have any type of Medical Insurance? ____Yes ____No
Does the patient have Marketplace Insurance? ____Yes ____No
Does the patient have Medicare? ____Yes ____No
Does the patient have Medicaid/HIP (Hoosier Healthwise)? ____Yes ____No
Has patient applied for any of the above? ____Yes ____No If Yes, Date ____________

Section B: Family Information: If you need more space please use the back of this form

Number of people filed on 1040 Tax Form? ___________

Please list below people other than self included in number above

Family Member Name	DOB	Relation to patient	Insurance, Marketplance, Medicaid, Medicare?

Section C: Family income information

Are you employed/Self-Employed? _____Yes ______No
Is your spouse employed/Self-Employed? _____Yes ______No ______Not Married
Monthly family income $ _______________

Section D: Verification of Income for you and your spouse is due within 30 days of today's visit: PLEASE PROVIDE ANY OF THE FOLLOWING THAT APPLY TO YOU AND YOUR FAMILY		
2 paycheck stub even if pay bi-weekly	SSI/Disability Award letter	If unemployed copy of WorkOne Statement
If self employed-last years taxes	Pension award letter	
Unemployment compensation letter	Copy of denial letter from Medicaid/Marketplace	

Section E: Signature

I hereby state that the information given herein, including the attachments, is complete, true, and correct to the best of my knowledge. I authorize any required verification, including a credit bureau report. I understand that if the information I provided is determine to be false or deceptive, I will be responsible for payment of the charges, as set forth on the applicable charge master in effect on the dates(s) service were rendered, for all services rendered. If at anytime I lose or I am denied coverage, I will be responsible for charges due to loss or denial of coverage. I understand that If I fail to follow through in the application process, or I refuse to apply for outside programs that might pay for the services that I may be denied Financial Assistance.

Applicant Signature:____ Date: ________________________

If your application is denied you have the right to appeal, please call 317-355-8708