The Jane Pauley Community Health Center

Caring for Our Communities

Financial Assistance Application

Section A: Patient Information			
Patient Name:		**DOB:**	**SSN (optional):**
Address:	**Apt:**	**City/State:**	
Zip Code:	**Phone Number:**	**Email:**	
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 Dental 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 the patient applied for Medicaid/HIP (Hoosier Healthwise)? ____Yes____No **If Yes, Date** _____

Section B: List all of those whom you claim on your taxes.				
Family Member Name	**DOB**	**Relation to patient**	**SSN**	**Insurance? Please list:**

Section C: Income	
Are you married? Yes/No	**Are you or your spouse employed/self-employed? Yes/No/Not Married**
Do you have sources of income in your household?	**Yes / No**
Total monthly household income (before taxes):	

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. I understand that if the information I provided is determined to be false or deceptive, I will be responsible for payment of the charges, as set forth on the application charge master in effect on the dates services were rendered, for all services rendered. If at any time I lose coverage, 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 / Guardian Signature:_____**Date:**_____

To file an appeal, please call: 317-934-0779

This is a reminder that all financial paperwork needs to be submitted within <u>30 days</u> of today's appointment to be eligible for the Sliding Fee Discount. If this paperwork is not received, you will be billed the full amount for any services that have been provided.

PLEASE PROVIDE ANY OF THE FOLLOWING THAT APPLY TO YOU AND YOUR FAMILY		
2 paycheck stubs (even if pay bi-weekly)	SSI/Disability Award letter	If unemployed, copy of WorkOne authorization
If self-employed, last year's taxes	Pension award letter	
Unemployment compensation letter	Copy of denial letter from Medicaid/Marketplace	

For Office Use Only

Employee Initials:	**Date:**