PARKVIEW HEALTH

Financial Assistance Application

Return signed Financial Assistance Application and required attachments by mail to:

Attention: ARS Team Patient Financial Services
Parkview Health
P.O. Box 5600
Fort Wayne, IN 46895

Or Fax to:
Parkview Patient Accounting
260-458-5811

Date application sent to patient:_____

For questions regarding the application, please call 260-266-6700 or toll free at 855-814-0012.

GUARANTOR

Guarantor Number: _____ Date of Birth:_____ Age: _____

Guarantor Name: Last: _____ First: _____ Social Security Number:_____

Home Address: _____ City/State/ZIP: _____

Home Phone Number:_____ Cell Number: _____

Patient Name: _____ Employer: _____

Names of Household Members Claimed as Dependents	Age	Relationship to Guarantor

INCOME

Guarantor's Total Monthly Income: $ _____
Spouse's Monthly Income: $ _____
Child Support Monthly Income: $ _____
Disability Monthly Income: $ _____
Social Security Income: $ _____
Rental Property Income: $ _____
Pension: $ _____
Unemployment Compensation: $ _____
Military Allotment: $ _____
Other Income (explain): $ _____

BANK ACCOUNTS

Balance in Checking Account: $ _____
Balance in Savings Account: $ _____
Other Investments (check all that apply): $ _____
❑IRA ❑CD ❑Stocks ❑Bonds ❑401K ❑403B ❑Annuities

MONTHLY EXPENSES

Expenses	Monthly Payment	Expenses	Monthly Payment
Mortgage Payment or Rent:	$ _____	Car Payment:	$ _____
Utilities:	$ _____	Student Loans:	$ _____
Internet/Cable:	$ _____	Child Support:	$ _____
Phone (Landline and Cell):	$ _____	Credit Cards:	$ _____
Medications:	$ _____	Miscellaneous (explain):	$ _____
Other Medical Bills:	$ _____	Miscellaneous (explain):	$ _____

Continued on back side

The Financial Assistance Policy requires certain documentation be attached to the Financial Assistance Application in order to document and substantiate your eligibility for financial assistance. Below is a checklist of the required attachments. Please indicate that you have attached the documents by checking the "Attached" checkbox. If the documents do not apply to you or your dependents, please check the N/A (not applicable) checkbox.

Attachment Required	Attached	Comments	N/A
Previous year's W2s and/or 1099 form for all employers.	❑		❑
Previous year's Federal Income Tax forms with all applicable schedules attached. If you do not file taxes, please explain why you do not do so.	❑		❑
Two most recent bank statements for checking, savings, CDs and Investment in stocks and bonds showing all transactions for the last 60 days.	❑		❑
Two most recent pay stubs for guarantor and spouse that show year-to-date income and deductions. If you are on medical leave or short-term disability, provide physician's statement of expected date to return to work.	❑		❑
If application is being made in the first two months of the new year, in addition to the most recent pay stubs, also provide the last paycheck of the previous year for all employers.	❑		❑
Copy of last two Social Security checks or bank statements showing automatic deposit of social security checks.	❑		❑
Copy of Pension check or bank statement showing automatic deposit of pension check.	❑		❑
Proof of Military income or Veteran's Administration income.	❑		❑
Proof of eligibility for Food Stamps.	❑		❑
Proof of unemployment benefits or job termination.	❑		❑
Proof of aid from the Township Trustee.	❑		❑
Proof of Section 8 Housing.	❑		❑
Proof of aid from CANI.	❑		❑
Proof of aid from a church or charitable organization.	❑		❑
Proof of dependents' eligibility for Hoosier Healthwise.	❑		❑
Letter from homeless shelters, halfway houses stating patient is a resident of the facility.	❑		❑
If family member is in a nursing home or assisted living, provide information from the center stating the monthly charges for care.	❑		❑
If receiving help from friends or family members, provide a letter from that party listing the types of assistance he/she provides.	❑		❑
If self-employed, provide year-to-date, itemized income and expenses.	❑		❑
Copies of all medical bills owing.	❑		❑
Copies of all prescription drug receipts.	❑		❑
Provide address of rental property and equity in rental property.	❑		❑
Provide market value of rental property.	❑		❑

I warrant the above application is complete and correct. I authorize Parkview Health to verify this information.

Guarantor Signature:_____ **Date**: _____

Spouse Signature: _____ **Date**: _____

– – – – FOR PATIENT ACCOUNTING USE ONLY – – – –

Family Size:_____ Date: _____ Approved/Denied: _____

Guidelines:_____ Reason: _____

FPL Income: _____ FPL Percentage: _____