Reid Health

FINANCIAL ASSISTANCE APPLICATION CHECKLIST

Today's Date: _____

***Provide copies of documents, as originals cannot be returned.**

- _____ Provide a copy of your Medicaid decision letter (all pages) with your application or documentation from contractor that assists patient with government assistance. The letter/documentation must be dated within the last 90 days and must state a reason for denial.
- _____ If you do not have primary insurance coverage, a copy of the print out from Marketplace (healthcare.gov or local DHHR) is required. Print out needs to state cost of your monthly premium to obtain health coverage. If premium is less than 10% of gross monthly income, premium is considered affordable and charity cannot be granted.
- _____ Provide a copy of your most recent Federal 1040 Income Tax Return Form and the W2.
- _____ Copies of pay stubs for the last 30 days
- _____ Current Social Security Award Letter
- _____ Pension benefits letter, Dividend/Interest Statement
- _____ Unemployment Benefit Letter
- _____ Workers Compensation Benefit Letter
- _____ If you have no income please have the attached letter of support filled out by the person or persons assisting you.
- _____ Copies of any outstanding medical bills (non-Reid Health Providers)
- _____ Prescription Drug List with prices from the pharmacy (Pharmacy Receipt Print-Out required)
- _____ Current Bank Statement for all Checking and/or Savings Accounts
- _____ Current Investor Statement for all CD's/Stocks/Bonds
- _____ Current Tax Assessment for all Assets
- _____ Alimony documentation

Please legibly complete the entire application. Attach the requested documentation and return it to your financial counselor at the address listed on the application.

** If you do not submit a complete Financial Assistance Application or do not include requested information by the due date, it could potentially delay the process or provide a cause for denial. **

Application Requirements – The following is a list of application requirements outlined in our Financial Assistance Policy. Please indicate your eligibility for each requirement below. If you do not meet these requirements your application will be denied. If you have exceptional circumstances and would like to speak with a representative, please contact us at 765-983-3184

Emergency Room Staff Only:

1. Service Area Requirement – The Financial Assistance program is designed for patients residing in our immediate service area. Financial Assistance will also be considered for out of area residents who arrive in our emergency room via ambulance or air ambulance and for out of pocket expenses when the patient carries third party insurance through commercial or government sources.

   ☐ State and County of Residence: _____

   ☐ Primary Insurance: _____

   ☐ Date of Emergency Room visit: _____

2. Medicaid (Medical Assistance) Application Requirement – Documentation of a denied Medicaid (Medical Assistance) application dated within the last 90 days is required for application.

   Have you applied for Medicaid coverage? Yes ☐ No ☐

   If yes, what is the status? ☐ Approved ☐ Pending ☐ Denied

3. International Patients: Only permanent residents are eligible for financial assistance. International students are not eligible for financial assistance.

   Are you a U.S. Citizen? ☐ Yes ☐ No

   If No, do you have a permanent resident card (green card)? ☐ Yes ☐ No

SECTION ONE: PATIENT INFORMATION – Please complete all information noted in this section.

Medical Record Number: _____

Applicant Name: _____
Last First Middle Initial

Address: _____ Primary Phone: ( ) _____

City: _____ State: _____ Zip Code: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer Name: _____ Address: _____

Secondary/Spouse Employer Name: _____Address:_____

☐

Is Insurance offered through Employer: ☐ Yes No

If yes, please provide the cost of employee portion: _____

Did you have health insurance (other than Medicaid) at the time of service: ☐ Yes ☐ No

If yes, please provide your insurance information and a copy of your insurance card

Name of Insurance:_____Effective Date: _____

Subscriber Name: _____Subscriber ID:_____Group #_____

SECTION TWO: FAMILY INFORMATION Please list for yourself and all other household members listed on your tax return

NAME	MRN	Relationship	Date of Birth	Applicant
				Yes/No
				Yes/No
				Yes/No
				Yes/No
				Yes/No

SECTION THREE: FAMILY INCOME Please provide income for yourself, your spouse and all other household members

Monthly Income Source	Total Family Income for 1 month prior to date of service	Type of Income verification attached. Proof of income is required to process your application.
Wages/Self Employment	**$**	**Copy of most recent federal tax return (or form 4506t), pay stubs for the last 30 days**

Social Security	**$**	**Social Security award letter**
Pension, Dividends, Interest, Rental Income	**$**	**Pension benefits letter, Dividend/Interest Statement**
Unemployment Worker's Compensation		**Unemployment benefit letter, Worker's Compensation benefit letter**

If you reported $0 income, please provide a brief explanation of how you (or the patient) are meeting basic living needs. Please also provide a letter of support from any individual assisting you:

_____

SECTION FOUR: MEDICIAL EXPENSES Medical expenses will be considered as an offset to income:

Medical Bill Type	Monthly Amount Paid	Verification Required
Hospital and Physician Bills (Non-Reid Health providers)	**$**	**Copies of bills**
Prescription Drugs	**$**	**Pharmacy receipt print out**
Other Medical Expenses	**$**	

SECTION FIVE: ASSETS please list all assets and their current value

Do you have?	Circle Choice	Description	Total Current Value	Type of Verification Required
Checking Accounts (total balances)	**Yes/No**			**Most current bank statement(s)**

Savings Accounts (total balances)	**Yes/No**			**Most current bank statement(s)**
CD's/Stocks/Bonds	**Yes/No**			**Most current investor statements**
Second Home (not your primary residence)	**Yes/No**			**Tax assessment**
Land	**Yes/No**			**Tax assessment**
Vehicles (cars or Trucks)	**Year**	**Make/Model**		**Tax assessment**
1.				
2.				
3.				
Camper/RV				**Tax assessment**
Other Recreational Vehicles (Boats/Motorcycles/ATVs)	**Yes/No**			**Tax assessment**
Other	**Yes/No**			**Tax assessment**

INCOME	MEDICAL EXPENSES	ASSESTS

TOTAL INCOME AFTER DEDUCTIONS:	

Please provide any additional information about assets listed above that you would like include in this application:

_____

_____

_____

_____

By my signing below, I certify that everything I have stated on this application and on any attachments are true.

Responsible Party Signature:_____Date:_____

Return to:
Reid Health
1100 Reid Parkway
Richmond, IN 47374
765-983-3184

Office Use Only

☐ Approved Date:_____

☐ Denied