Dear Patient,

**Application Instructions**

If you wish to apply for the Providence Health Services Financial Assistance Program, please complete and return the attached Application. If you have any questions, a Financial Assistance Representative can assist you by calling 800-566-5050.

**ELIGIBILITY**

In order to qualify for Financial Assistance, please note the following:

- An Application for local, state, or federal aid may be required.
- **Household income must be verified. Please provide proof of household income. (Tax return and/or recent pay stubs) If you have no income, please provide a statement explaining how you are supported financially.**
- Other income sources must also be reported and include: child support, alimony, workers compensation, public assistance, self-employment income, and unemployment income.

**Financial Assistance is not available for:**

- Personal items, such as television expenses.
- Service that is not medically necessary including cosmetic procedures and infertility treatments
- Service covered by insurance in another health care network.
- Over-the-counter pharmaceutical items.

***Determination of Financial Assistance shall only be applicable to the episode of care for which this Application is being completed.***

**Mail completed application and documentation to**:

NRSC Financial Assistance Representative
10330 N. Meridian Street, 2N PFS
Indianapolis, Indiana 46290

**Fax completed application and documentation to**:

(317) 583-2753 Attn: NRSC Financial Assistance Representative

If you have any questions please contact our Customer Service Center at 800-566-5050
Monday through Friday 8:00 AM – 1:45 PM & 2:30 PM – 4:00 PM EST.


## FINANCIAL ASSISTANCE APPLICATION

| PATIENT INFORMATION (PLEASE PRINT) | | | | Account No. | |
|---|---|---|---|---|---|
| Patient Name: | Birth Date | Marital Status | Sex | | Telephone No. |
| Address: | City | State | Zip | | Email Address |
| Social Security Number: | Employer | | Full Time<br>Part Time | | How many hrs/wk |
| Employer Address: | City | State | Zip | | Telephone No. |

| RESPONSIBLE PARTY'S INFORMATION | | | | | |
|---|---|---|---|---|---|
| Name<br>Same as above | Birth Date | Marital Status | Sex | | Telephone No. |
| Address | | State | Zip | | Email Address |
| Social Security Number | Employer | | Full Time<br>Part Time | | How many hrs/wk |
| Employer Address | City | State | Zip | | Telephone No. |

| RESPONSIBLE PARTY SPOUSE INFORMATION | | | | | |
|---|---|---|---|---|---|
| Spouse's Name | | Social Security Number | | | Birth Date |
| Spouse's Employer: | Address: | City | State | Zip | Telephone No. |

**DEPENDENTS:**

| Name | Age | Relationship | Name | Age | Relationship |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| GROSS MONTHLY INCOME | |
|---|---|
| Applicant Earned Income | |
| Applicant Spouse's Income | |
| Social Security Benefits | |
| Pension/Retirement Income | |
| Unemployment Compensation | |
| Worker's Compensation | |
| Interest / Dividend Income | |
| Child Support | |
| Alimony | |
| Rental Property Income | |
| Food Stamps | |
| Other | |
| Other | |
| ***TOTAL GROSS INCOME:*** | |

| ASSETS | |
|---|---|
| Cash on Hand | |
| Savings Account | |
| Checking Account | |
| C.D.'s | |
| Securities | |
| Life Insurance | |
| Other Real Estate | |
| Other | |

| Vehicle / Make & Model: | Year | Value |
|---|---|---|
| | | |
| | | |
| | | |

| Financial Settlements: | |
|---|---|
| Life Insurance | |
| Inheritance | |
| Other | |
| **TOTAL VALUE OF ASSETS:** | |

| MONTHLY LIVING EXPENSES | Payment | Balance |
|---|---|---|
| Mortgage/Rent | | |
| Electricity | | |
| Gas | | |
| Telephone | | |
| Water | | |
| Groceries | | |
| Cable TV | | |
| Car Payment | | |
| Cell Phone | | |
| Day Care | | |
| Child Support/Alimony | | |
| Prescription Drugs | | |
| **Credit Cards:** | | |
| 1. | | |
| 2. | | |
| 3 | | |
| **Other Doctor / Hospital Bills:** | | |
| | | |
| | | |
| | | |
| | | |
| **Insurance Expense:** | | |
| 1. Automobile | | |
| 2. Property | | |
| 3. Medical / Life | | |
| **Other Loan Payments:** | | |
| 1. | | |
| 2. | | |
| **Other Monthly Payments:** | | |
| cobra | | |
| life insurance | | |
| 3. | | |
| **TOTAL MONTHLY EXPENSES:** | | |

***COMMENTS:*** _____

I hereby certify that the above information is true and complete to the best of my knowledge. I hereby authorize the hospital to obtain information from external credit reporting agencies if the hospital deems necessary.

Date

Signature of Patient, Spouse, Guarantor or Legal Representative

**PROVIDENCE HEALTH SERVICES**
**FINANCIAL ASSISTANCE APPLICATION**

## CERTIFICATION

My signature on this form certifies that all the statements are true to the best of my knowledge and that I have disclosed all facts concerning my finances. I understand and acknowledge that any misrepresentation of my finances in connection with this Application, or any failure to cooperate with efforts to qualify me for programs which may cover the cost of my care (for example, Medicaid, personal injury claim, workmen's compensation) may invalidate any award of Financial Assistance and that I will be financially liable for the services provided. I agree to allow Providence Health Services or its representatives to request and review a report of my credit and to take other reasonable steps to validate all information provided.

I understand that if I qualify for partial financial assistance I will be responsible for payment of the remaining portion of my bill.

**Statement Regarding Gross income (before taxes and withholding)**

**My Total Yearly Household Income** (add the Patient and Spouse Yearly Columns from other side and write the total below):

_____

**Statement Regarding Lack of Income**

Briefly describe your financial/living situation and why you need financial assistance with your medical bill(s).

_____

_____

_____

_____

_____

_____

_____

_____

**Please Sign Below:**

_____

Patient /Guardian (Date)