Self-Employment Worksheet
Financial Assistance Program

Patient Name: _____

Account Number: _____

Dear Guarantor,

In order to properly process your application for financial assistance under the Riverview Health Financial Assistance Program, we need to verify your wages. Due to your self-employed status, you may be unable to produce the routine documentation required for income verification.

Please provide the following information for the past eight weeks:

	Dates	Business Income	Business Expense	'Take Home' Pay
1				
2				
3				
4				
5				
6				
7				
8				
	Total			

Return this information, along with your completed application and other required documentation to:

Riverview Health Patient Accounts
Attn: Financial Counselor
395 Westfield Rd
Noblesville, IN 46060

If you have questions about or need assistance to complete this application process, please contact the Patient Accounts department at 317.776.7141 8:00 a.m. to 4:30 p.m. Monday through Friday.

Application Certification:
I certify that the information in this application is true and correct to the best of my knowledge. I understand that the information provided may be verified by Riverview Health, and I authorize Riverview Health to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information or withhold relevant information, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed and I will be responsible for the balance.

_____ _____

Guarantor Signature Date