

# Financial Assistance Application



Patient Name: \_\_\_\_\_  
 Account Number: \_\_\_\_\_

**Important: You may be able to receive free or discounted care.**

In order for Riverview Health to determine eligibility for financial assistance, please complete this form as soon as possible after the date of service. We will accept your application for up to 240 days following the date of the first post-discharge patient statement.

Guarantor Information				
Name	Date of Birth	Preferred Phone Number		
Home Address	City	State	Zip Code	County of Residence
Applicant's Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow				
Social Security Number	Health Insurance Information	Employer		
Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Self-Employed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed				

**Please list everyone in your household below - include yourself and all individuals eligible to be listed on your federal tax return. For households larger than five members, please attach a list of additional household members.**

Full Legal Name	Date of Birth	Social Security Number	Relationship

Gross Monthly Income		Monthly Expenses	
Guarantor's Gross Income	\$	Mortgage/Rent	\$
Investment Income (Annuities/Stocks/Dividends)	\$	Insurance (Health/Life/Auto/Homeowners/Renters)	\$
Rental Property Income	\$	Utilities (Electricity/Gas/Water/Phone)	\$
Pension/Retirement/Unemployment	\$	Credit Cards/ Other	\$
Other Household Gross Income	\$	Car Payment	\$
Other:	\$	Child Care	\$
Other:	\$	Child Support/Alimony Paid	\$
		Medical & Pharmacy Bills	\$
Income Total	\$	Total Expenses	\$

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Questionnaire	
Did you have health insurance on the date(s) services were provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you applied for Medicaid or other state or federal assistance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Were the services provided related to any of the following? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Accident <input type="checkbox"/> Crime <input type="checkbox"/> Workplace Injury <input type="checkbox"/> Other:	If yes, date of injury

## Presumptive Eligibility

Uninsured patients or guarantors who **provide proof of eligibility** for one of the programs listed below, are automatically eligible to receive assistance. Please proceed to bottom of page to sign the Application Certification and submit with **proof of eligibility** for the applicable program(s).

## Check as many as apply and provide supporting documentation:

<input type="checkbox"/> TANF	<input type="checkbox"/> SNAP
<input type="checkbox"/> WIC	<input type="checkbox"/> Patient Deceased with No Estate
<input type="checkbox"/> Indiana Children's Special Health Care Services	<input type="checkbox"/> Homeless
<input type="checkbox"/> State Medicaid Programs (you or a dependent)	

## Required Information and Supporting Documentation

### Valid Government-Issued Photo ID:

- Driver's license, passport, etc.

### Tax Documents (Submit all that apply):

- Most recent State and Federal Income Tax forms including Schedules C, D, E and F if filed

### Proof of Income for all Household Members (Submit all that apply):

- Most recent two months of employer/unemployment stubs
- Self-Employment Worksheet (available online at Riverview.org/financial-assistance)
- Supporting documentation for all additional sources of income (e.g., SSI, IRAs, annuities, etc.)
- Court documents if applicable

If an applicant does not have any of the listed documents to prove income, he or she may call the Patient Accounts department to discuss other evidence that may be provided to demonstrate eligibility.

## 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

## Submit completed applications:

In person or by mail  
 Riverview Health-Patient Accounts  
 Attn: Financial Counselor  
 395 Westfield Rd  
 Noblesville, IN 46060

## Need Assistance?

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.