Community Health Network

APPLICATION FOR FINANCIAL ASSISTANCE

Thank you for giving us the opportunity to serve your healthcare needs and for expressing interest in our Financial Assistance Program.

Please complete this application and return it along with **all supplemental documentation required within 15 days** to avoid possible denial of your application. The information you provide will be held in strict confidence and will not be used for any purpose other than to assess your need for financial assistance. We will not share this information with any person or organization outside of Community Health Network.

Please provide the following information completely and accurately. Information is subject to verification. Please attach a list of additional household members if there are more than five (5) members.		
Patient Name (First, MI, Last)	SSN	Total # of household members
Address	Date of Birth	Home/Cell Phone
City/State/ZIP		Work Phone
Guarantor Name	Account #	

Dependents may live outside of your primary household residence if they are claimed on your or your spouse's tax return.

List ALL household member names	Date of Birth	SSN	Relationship to Patient	Insurance
1		- -		Yes / No
2		- -		Yes / No
3		- -		Yes / No
4		- -		Yes / No
5		- -		Yes / No

Monthly Budget

Gross Monthly Income (GMI)		**Transportation:**	
Source:	$	Gas & Oil	
Source:	$	Total	$ _____
Source:	$	**Medical/Health:**	
Source:	$	Current Bills	$ _____
Source:	$	Medications	$ _____
Total	$ _____	Total	$ _____
Monthly Expenses		**Insurance:**	
Housing:		Auto Insurance	$
Mortgage/Rent	$	Health Insurance	$
Total	$ _____	Homeowners/Renter Insurance	$
Utilities:	$	Life Insurance	$
Electricity/Gas/Water	$	Total	$ _____
Internet/Cable	$	**Debts:**	
Phone/Mobile	$	Car Payment(s)	$
Trash	$	Child Care	$
Total	$_____	Credit Card(s)	$
Food:		Student Loans	$
Groceries	$	Other	$
Total	$ _____	Total	$ _____
		Total Expenses	**$** _____

I CERTIFY that the information I have provided is a true and accurate representation of my family size and household income. I understand that any misrepresentation of this information will result in denial of financial assistance. I authorize Community to access additional sources of information to verify my qualification for assistance.

Applicant/Patient Signature_____ Date_____

Spouse Signature (if co-applicant)_____ Date_____

Thank you for your application and for the opportunity you have given us to serve your health care needs. Please return your completed application and all supporting documentation to: **Fax Number: 317.355.8778, Email: billinghelp@ecommunity.com or U.S. Mail Address: 6435 Castleway West Drive, Indianapolis, IN 46250. Please call 317.355.5555** if you have any questions or need assistance with this application. **We will notify you of our decision in writing within 45 days of the receipt of your application.**