Date Requested _____

Community Hospital Anderson

APPLICATION FOR FINANCIAL ASSISTANCE

Thank you for choosing Community Hospital Anderson to serve your health care needs and for expressing interest in our Financial Assistance Program.

Please complete this application and return it along with all supplemental documentation required within **fifteen (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 Hospital Anderson. Furthermore, the information may be sent to Community Health Network and other medical providers as a result from your stay with Community Hospital Anderson at applicant's request.

Please provide the following information so we can better understand how many people are in your family. Dependents may live outside of your primary household residence if they are claimed on your (or your spouse's) Federal income tax return.

APPLICANT NAME_____ TELEPHONE #_____ DATE OF BIRTH_____

SOCIAL SECURITY NUMBER _____-_____-_____ EMAIL_____

STREET ADDRESS_____ CITY_____ STATE_____ ZIP_____

SPOUSE / DEPENDENT FAMILY INFORMATION (include an additional page if more space is required to list dependent family members)

NAME	RELATIONSHIP	SSN	DATE OF BIRTH

FAMILY FINANCIAL INFORMATION

What is your monthly household, pre-tax (gross), spendable income from all sources such as, but not limited to: wages, salaries, tips, commissions, pensions, Social Security, interest, investments, rent, royalties, disability benefits, unemployment compensation, etc? **$_____**

Please submit unaltered copies of the following documents:

- The first two (2) pages of your most recent FEDERAL 1040 TAX RETURN and your spouse's if you filed separately. [If anyone is self-employed a copy of the complete FEDERAL 1040 TAX RETURN must be included.]
- The last three (3) paycheck stubs for all income earners in the household (including verification of Social Security, pensions, unemployment compensation, etc.).
- Bank statements (both checking and savings) for the past three (3) months for all accounts in the household including business accounts.
- Proof of SNAP (food stamps), HUD, or TANF.

ADDITIONAL QUALIFICATION INFORMATION

I/WE **CERTIFY** that the information provided is a true and accurate representation of my/our family size and household income. Community Hospital Anderson is authorized to check my/our credit and employment history and to answer questions as to your credit experience with me/us. I/we understand that any misrepresentation of this information will result in a denial of financial assistance.

Applicant/Guarantor Signature_____ Date_____

Co-Applicant/Spouse Signature_____ Date_____

Please return your completed application and all supporting documentation in the postage-paid envelope provided. Mailing address is: 1515 N Madison Ave, Anderson, IN 46011. Customer Service for any questions or assistance with this application: 765.298.3300.