PARKVIEW HEALTH

Financial Assistance Application

Return signed Financial Assistance Application and required attachments

by fax to: Parkview Patient Accounting: 260-458-5811

Or mail to: Attention: ARS Team Patient Financial Services
Parkview Health
P.O. Box 5600
Fort Wayne, IN 46895

Date application sent to patient:_____

For questions regarding this application, please call 260-266-6700 or toll free 855-814-0012.

GUARANTOR

Guarantor Number: _____ Date of Birth:_____/_____/_____ Age: _____

Guarantor Name: Last: _____ First:_____ Social Security Number: _____

Home Address:_____ City:_____ State:_____ ZIP:_____

Home Phone Number:_____ Cell Number: _____

Patient Name: _____ Employer: _____

All Household Members Claimed as Dependents	Date of Birth	Insurance Coverage?	Insurance In Network?	Name of Insurance
_____	___/___/_____	❑Yes ❑No	❑Yes ❑No	_____
_____	___/___/_____	❑Yes ❑No	❑Yes ❑No	_____
_____	___/___/_____	❑Yes ❑No	❑Yes ❑No	_____
_____	___/___/_____	❑Yes ❑No	❑Yes ❑No	_____
_____	___/___/_____	❑Yes ❑No	❑Yes ❑No	_____
_____	___/___/_____	❑Yes ❑No	❑Yes ❑No	_____

INCOME

Guarantor Monthly Income: $_____ Rental Property Income: $_____

Spouse Monthly Income: $_____ Pension Monthly Income: $_____

Disability Monthly Income: $_____ Unemployment Compensation: $_____

Social Security Monthly Income: $_____ Military Allotment: $_____

1. Were you an Ohio Resident at the time of your hospital service? ❑Yes ❑No
2. Did you have Medicaid at the time of service? ❑Yes ❑No
3. Did you have health insurance or other auto/liability insurance at the time of service? ❑Yes ❑No
   (Please attach a copy of Medicaid or Insurance that has not paid on this bill)

ASSETS / RESOURCES

Please indicate if you or anyone in your household has any of the following assets/resources:

Household Member	Type	Value
_____	Total Checking Account(s): _____	_____
_____	Total Savings Accounts(s): _____	_____
_____	Other (CDs, Stocks, Bonds, Money Markets, etc.): _____	_____

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PARKVIEW HEALTH

Financial Assistance Application Checklist

Application

- ❑ Completed and signed application for financial assistance

Gross Income

- ❑ Two (2) most recent pay stubs, for guarantor and spouse, showing year-to-date gross income and deductions (If HCAP eligible patients may be required to provide up to three (3) years of income verification)
- ❑ If application is being submitted in the first two (2) months of the new year, in addition to the most recent pay stubs, please also provide the last pay stub for the previous year for guarantor and spouse
- ❑ If self-employed, please provide year-to-date itemized income and expense summary
- ❑ If you are on medical leave or short-term disability, provide physician's statement or patients expected return to work date – with verification of year-to-date disability income
- ❑ Proof of unemployment benefits and/or a letter of separation/termination verifying date employment ended, if not currently employed
- ❑ Copy of current year Social Security and/or VA Benefit letter indicating gross monthly benefits (Social Security 800-772-1213)
- ❑ Provide address of rental property(s), equity and market value of rental property(s)

Taxes

- ❑ Previous year's Federal Income Tax Return 1040 form with all applicable schedules attached. If you have not filed taxes, please explain why. State tax return is not required. (If you do not have a copy of tax return, you can visit www.irs.gov or call 800-908-9946 to order a "Federal Tax Transcript".)
- ❑ Previous year's W2 and/or 1099 Form(s) for all income sources, e.g. Social Security, military, Retirement, Pension, unemployment, Interest and miscellaneous Income

Bank Statement

- ❑ Two (2) most recent bank statements for all personal and/or business accounts, CDs and investments in stocks and bonds – showing all transactions – for the last 60 days. (For the bank statements, "Complete" means that if the statement says, "page 1 of 6", all 6 pages are needed, even if some of them are intentionally left blank.)

Miscellaneous

- ❑ If a household member is in a long-term care facility or an assisted living facility, please provide information from the facility indicating the monthly charges for care
- ❑ If receiving help from friends or family members, please provide a letter from that party listing the types of assistance they provide
- ❑ Provide supporting documents from any County, State and/or Federal program(s) for which you qualify
- ❑ Indicate below whether or not you have already applied for assistance through any of these programs and were found to be ineligible for assistance (Y = Yes; N = No):

  Welfare/Medicaid (800-403-0864)_____ Disability (866-770-1735)_____

Processing your application can take 10–14 days. If additional information is required additional processing time will be needed. During the financial counseling process, we will determine if you qualify for health insurance coverage through federal or state programs such as Medicaid. If you are eligible for one of these programs, we may ask that you apply for coverage. Our team at The WellFund will reach out to you. They can also be reached at 260-203-0933.

I warrant the above information is complete and correct. I authorize Parkview Health to verify this information.

Guarantor Signature:_____ **Date**: _____

Spouse Signature: _____ **Date**: _____