Hendricks Regional Health Medical Group
Attention: Ruby
1100 Southfield Drive, Suite 1370
Plainfield, Indiana 46168

Thank you for your request for a Hendricks Regional Health Medical Group Financial Assistance Application. We have enclosed on for your completion along with some information about our Financial Assistance Policy. We also need COPIES ONLY of the documents requested on the Application. Many of the documents listed will not apply to you, just send copies of the ones that do.

If you have any questions, please call the number below.

Thank you again,

Ruby
Patient Financial Assistance
Hendricks Regional Health Medical Group
317-837-5566

Hendricks
Regional Health

FINANCIAL ASSISTANCE APPLICATION

Hendricks Regional Health Medical Group

Part of being your indispensable healthcare partner means offering a patient-friendly Financial Assistance Program. Opportunities for assistance are available to all qualifying patients – regardless of whether you have insurance. Please complete this Financial Assistance Application, and be sure to provide the requested supporting documentation for your Application to be processed.

PATIENT INFORMATION

Patient Name: _____

Phone (Home): _____ Phone (Mobile): _____ Email: _____

Address: _____

(Street Address) (PO Box)

_____

(City) (State) (Zip Code)

Date of Birth: _____ SS#: _____

ACCOUNT INFORMATION

Patient Name	Account Number	Service Date	Balance
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Use additional sheets for additional accounts)

HOUSEHOLD INFORMATION

Name:	Age	Relationship	Employer
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Use additional sheets for additional family members)

CURRENT ANNUAL INCOME

Patient/Responsible Party (if Patient is a minor) Income (before taxes) $_____

Spouse Income (before taxes) $_____ Social Security/Disability $_____

Unemployment $_____ Child Support Received $ _____

Pension/Retirement $_____

Other income not listed about $_____ Source _____

Hendricks
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CURRENT ASSETS

Checking Account #_____ Bank_____ Balance $_____
Savings/Money Market Account #_____Bank_____ Balance $_____
Certificate of Deposit Account # _____Bank_____ Balance $_____

I have a lawsuit, settlement, personal injury, or liability claim pending on Account #_____
☐Yes ☐No If Yes, provide details _____

I have applied for Medicaid or other governmental program(s):
☐Yes ☐No If Yes, provide details _____

I certify under the penalty of perjury that all of the information provided as part of this Financial Assistance Application is true and accurate. I understand that the information supplied in this application is subject to verification by Hendricks Regional Health and hereby authorize any holder of information supplied in this application to release such information to Hendricks Regional Health for purposes of this application. I further understand that failure to disclose information requested in this application or disclosure of erroneous information will cause the application to be denied. I also agree to apply for state or federal assistance prior to an award of financial assistance, if applicable. If I am entitled to any action against or settlement from third party payers, I will take any action necessary or requested by Hendricks Regional Health to take such action and will assign to Hendricks Regional Health, all amounts recovered up to the total amount of the outstanding balance on my bill.

_____ _____
Applicant Signature Date

_____
Relationship to Patient (if not patient)

REQUIRED DOCUMENTATION

Along with your Financial Assistance Application please send copies of the following documents (only send the information that applies to you): Prior year's federal income tax returns; Prior year's W-2s or 1099s; Most recent statements from all checking and savings accounts (include all pages); Most recent two (2) months of pay stubs, or statement from employer documenting earned wages; Social Security/Disability Benefit letter, if applicable; Unemployment Statement including either Work one KVP450 or KWE356 Form, if applicable; Copy of child support order, if applicable; Valid Picture ID; Health insurance cards (front and back), if applicable.

Mail application and documents to:
Hendricks Regional Health Medical Group
Attention: Ruby
1100 Southfield Drive, Suite 1370
Plainfield, IN 46168