Dearborn County Hospital Financial Assistance Application

This application is for Dearborn County Hospital (DCH) charges, including our Home Health & Hospice services.

You may qualify for this program if your income is at or below the following guideline:

Family Size	DCH Financial Assistance Program **2017** Income Guidelines
1	$30,150
2	$40,600
3	$**51,050**
4	$61,500
5	$71,950
6	$82,400

For families/households with more than 6 persons, add $4,180 for each additional person.

If you wish to apply, please complete all sections below and mail back with required documents to:

Dearborn County Hospital 600 Wilson Creek Rd. Lawrenceburg, IN 47025 (questions call 812-537-8220)

Account Number (list only one): _____ Patient's Name:_____

GUARANTOR INFORMATION:

RELATIONSHIP TO PATIENT: NAME:

CITY STATE ZIP COUNTY

AGE SOC SEC# HOME PHONE WORK PHONE

EMPLOYER OCCUPATION

SPOUSE INFORMATION:

RELATIONSHIP TO PATIENT: NAME:

CITY STATE ZIP COUNTY

AGE SOC SEC# HOME PHONE WORK PHONE

EMPLOYER OCCUPATION

HOUSEHOLD INFORMATION:

1. Do you rent or own your home? _____ RENT _____ OWN How long at current address? _____
2. Number of dependents in your home _____ Ages _____/_____/_____/_____/_____/_____/_____
3. Total monthly earnings (attach proof of income) $_____
4. Balance of savings/investment account(s) $_____
5. Balance of checking account(s) $_____
6. Number of vehicles: _____ Make/Model _____/_____, _____/_____, _____/_____
7. Describe other property owned: _____
8. What are your monthly expenses?

$_____ Mortgage/Rent	$_____ Food	$_____ Medical bills	$_____ Electric
$_____ Other loans	$_____ Auto payment	$_____ Utilities	$_____ Health Ins.
$_____ Auto Ins.	$_____ Telephone	$_____ Medication	$_____ Other/Credit card

Total Monthly Expenses $_____

9. If you have indicated there is no income, please write a brief description explaining why and how you are paying current expenses. _____

REQUIRED DOCUMENTS:

Please check income verification attached:

- ☐ Income verification (ex. paystub, W-2, Tax Return)
- ☐ SSI, Alimony, Unemployment or Child Support

☐ CHECK THIS BOX IF YOU HAVE ALREADY APPLIED FOR MEDICAID.

I certify that the information contained in this statement is correct and complete. And, I authorize the hospital to verify any of the information contained herein. Lastly, I understand that falsification or incomplete information is cause for denial or revocation.

Signature: _____ (This document must be signed or it will be returned.) Date:

DEARBORN COUNTY HOSPITAL

Information needed to complete the Financial Aid Application

In order to review your account for charity care, the following information is required. THIS DOES NOT GUARANTEE YOUR ACCOUNT WILL BE WRITTEN OFF IN PART OR IN WHOLE TO CHARITY CARE, BUT IS NEEDED TO DETERMINE ELIGIBILITY.

_____Financial Statement

_____Income Verification (ex: pay stubs for the past 60 days, W-2, tax return for the most recently filed year, social security checks, deposits, bank statements or other documentation).

_____Medicaid/HIP denial (Contact Social Services @ 812-537-8474)

_____Proof of Medical Expenses from Other Providers

_____Proof of Monthly Prescription Medication Expenses

If you have any questions concerning the Financial Application or documentation needed to determine eligibility, please call the Patient Accounting department at: 812-537-8220.