Highpoint Health Financial Assistance Application

This application is for Highpoint Health charges, including our Home Health & Hospices services. COMPLETING THIS APPLICATION DOES NOT GUARANTEE YOUR ACCOUNT WILL BE WRITTEN OFF IN PART OR IN WHOLE TO CHARITY CARE BUT IS NEEDED TO DETERMINE ELIGIBILITY.

You may qualify for this program if your annual income is at or below 400% of the Federal Poverty Guideline:

Family Size	2020 Federal Poverty Guidelines (FPG)	400% of FPG
1	$12,760	$51,040
2	$17,240	$68,960
3	$21,720	$86,880
4	$26,200	$104,800
5	$30,680	$122,720
6	$35,160	$140,640

For families/households with more than 6 persons, add $4,480 for each additional person.

If you wish to apply, please complete all sections below and mail back with required documents to:
Highpoint Health 600 Wilson Creek Rd. Lawrenceburg, IN 47025 (questions call: 812-537-8404)

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

Guarantor Information:

Last Name First M.I.	Date of Birth	Social Security Number - -
Street Address Apt. # City	State Zip Code	Home Phone:
Email Address:	Do you have Medicaid Benefits? Y/N	Cell Phone:
Employer:	Occupation:	Do you have insurance? Y/N
Insurance Company:	Insurance Group #:	Insurance Member ID:

Dependents and Income Information:

Please list your name, spouse's name and dependents under the age of 18. List gross monthly income amounts below for all members of your household with income.

Name	Income Source (Employment, Social Security, Self-employment, Pension, etc.)	Gross Monthly Income

Assets Information:

Balance of Savings Account(s):	
Balance of Checking Account(s):	
Balance of Non-Retirement Investment Account(s):	
Value of Non-Primary Residence Real Estate:	

Required Documents:

Employment Income:	Most recent paystub with year to date total income or last year's W-2
Unemployment Income:	Most recent unemployment insurance payment stub
Self-Employment Income:	Copy of last year's tax return
Social Security Income:	Most recent proof of Income letter with Social Security benefit information
Pension/Retirement Income:	Last statement of pension/retirement income
Alimony/Child Support Income:	Last alimony/child support statement

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APPLICANT CERTIFICATION: I certify that this information is true and correct to the best of my knowledge. I will apply for any state, federal, or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the above information. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

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Applicant Signature **Date**

If you have any questions concerning the Financial Application or documentation needed to determine eligibility, please call the Patient Accounting department at: 812-537-8404.