



COLUMBUS REGIONAL HEALTH

Financial Application for Columbus Regional Health

Please complete all sections of this application to the best of your ability and provide supporting documentation as listed below. If you would like to provide additional information of any kind that you feel will help us better understand your situation, please attach a letter to this application. Once all of the required information is received, you will receive a letter advising you of the decision. If you have questions concerning the application or need assistance, please call Customer Service at (812) 376-5315 or toll free at (800) 841-4954. Customer Service is available to assist Monday through Friday from 8:00 am to 4:30 pm. Return completed and signed application along with copies of supporting documentation to the address below.

Columbus Regional Hospital
Attn: Patient Financial Services
2400 East 17th Street
Columbus, IN 47201

Please submit copies of the following supporting documentation along with your application form:

1. Last year's Federal tax return (1040) and any attached schedules
 - a. If you are self-employed, provide a copy of the self-employment tax return
2. Last three (3) paycheck stubs
3. Social Security, Disability, and / or Unemployment Award letters
4. Current Bank Statement
5. **APPLICATION DUE BACK BY** _____

Today's Date: _____		Hospital or Guarantor #: _____		Amount of Bill: _____	
Responsible Party Information				Email: _____	
Name: _____		Sex: M F	Age: _____	Date of Birth: _____	
Social Security Number: _____		Marital Status: M S W D		Telephone No. _____	
Current Street Address: _____					
City: _____		State: _____		Zip: _____	
Occupation: _____					
Responsible Party Spouse / Partner Information					
Spouse / Partner Name: _____		Sex: M F	Age: _____	Date of Birth: _____	
Social Security No: _____		Occupation: _____			
Dependents (Living in household and claimed on taxes):					
Full Name	Date of Birth	Age	Relationship to Guarantor		
_____	_____	_____	_____		
_____	_____	_____	_____		
_____	_____	_____	_____		
_____	_____	_____	_____		
Did you and / or your spouse / partner file taxes last year? Yes No					
If no, why not? _____					
Has anyone else claimed you or any others listed on this application, as a dependent on their taxes? If so, who _____?					

Employer Name	Hours Per Week	Hourly Rate / Salary	Frequency Paid
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Gross Monthly Income	Dollar Amount	Assets	Dollar Amount
Income from Rental Property	_____	Cash on hand	_____
Alimony	_____	Checking Accounts	_____
Child Support	_____	Savings Accounts	_____
Pension	_____	Other	_____
VA Benefits	_____	*Asset testing is performed as required by CMS for balances related to hospital services.	
Retirement Account (if receiving payout as part of income)	_____	Monthly Expenses	Dollar Amount
Investment Income (if receiving payout as part of income)	_____	Mortgage / Rent	_____
Unemployment	_____	Gas	_____
Do you receive Food Stamps?	_____	Electric	_____
Do you receive subsidized housing?	_____	Water	_____
SS Income	_____	Cable	_____
Disability Income	_____	Telephone / Cell Phone	_____
Other	_____	Food	_____
1. _____	_____	Auto Payments	_____
2. _____	_____	Child Support	_____
		Alimony	_____
		Other	_____
		1. _____	_____
		2. _____	_____

Other Medical Bills:

1. _____

2. _____

3. _____

Other information you would like us to know: _____

I am requesting financial assistance for services received at Columbus Regional Health. I certify that the information I have provided is true and accurate. I authorize Columbus Regional Health to verify the information given, including the Credit Rating Bureau and employment. I understand that any information found to be misleading or untrue may result in denial of assistance. I understand that I am responsible for any balances not covered by financial assistance. Financial assistance is granted with the understanding that there is no insurance to cover your out of pocket expenses. If there is an insurance payment made at a later date (directly by insurance or through a legal settlement), payment will be accepted and applied to any financial assistance adjustment as recovery.

Signature

Date

Spouse Signature

Date

A signature is required to process your application.

For Office Use Only

Total Income: _____ Approved or Denied: _____

Date Reviewed: _____ Financial Counselor Initials: _____