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. **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
Income from Rental Property	
Alimony	
Child Support	
Pension	
VA Benefits	
Retirement Account (if receiving payout as part of income)	
Investment Income (if receiving payout as part of income)	
Unemployment	
Do you receive Food Stamps?	
Do you receive subsidized housing?	
SS Income	
Disability Income	
Other	
1.	
2.	

Other Medical Bills:	
1.	
2.	
3.	

Assets	Dollar Amount
Cash on hand	
Checking Accounts	
Savings Accounts	
Other	
Other	

Monthly Expenses	Dollar Amount
Mortgage / Rent	
Gas	
Electric	
Water	
Cable	
Telephone / Cell Phone	
Food	
Auto Payments	
Child Support	
Alimony	
Other	
1.	
2.	

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:_____