Financial Assistance Application

Patient Name: _____ **Account Number:** _____

Important: You may be able to receive free or discounted care.
In order for Riverview Health to determine eligibility for financial assistance, please complete this form as soon as possible after the date of service. We will accept your application for up to 240 days following the date of the first post-discharge patient statement.

Guarantor Information				
Name	Date of Birth	Preferred Phone Number		
Home Address	City	State	Zip Code	County of Residence
Applicant's Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐Widow				
Social Security Number	Health Insurance Information	Employer		
Employment Status ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Unemployed				
Pay schedule: ☐Every week ☐Every other week ☐Every month ☐Every other month ☐ Other or N/A				

Please list everyone in your household below - include yourself and all individuals eligible to be listed on your federal tax return. For households larger than five members, please attach a list of additional household members.

Full Legal Name	Date of Birth	Social Security Number	Relationship

Gross Monthly Income		Monthly Expenses	
Guarantor's Gross Income	$	Mortgage/Rent	$
Investment Income (Annuities/Stocks/Dividends)	$	Insurance (Health/Life/Auto/Homeowners/Renters)	$
Rental Property Income	$	Utilities (Electricity/Gas/Water/Phone)	$
Pension/Retirement/Unemployment	$	Credit Cards/ Other	$
Other Household Gross Income	$	Car Payment	$
Other:	$	Child Care	$
Other:	$	Child Support/Alimony Paid	$
		Medical & Pharmacy Bills	$
Income Total	$	Total Expenses	$

Questionnaire

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Did you have health insurance on the date(s) services were provided?	☐ Yes ☐ No
Have you applied for Medicaid or other state or federal assistance?	☐ Yes ☐ No
Were the services provided related to any of the following? ☐ Yes ☐ No If yes, ☐ Accident ☐ Crime ☐ Workplace Injury ☐ Other:	If yes, date of injury

Presumptive Eligibility

Uninsured patients or guarantors, who ***provide proof of eligibility*** for one of the programs listed below, are automatically eligible to receive assistance. Please proceed to bottom of page to sign the Application Certification and submit with ***proof of eligibility*** for the applicable program(s).

Check as many as apply and provide supporting documentation:

☐ TANF	☐ SNAP
☐ WIC	☐ Patient Deceased with No Estate
☐ Indiana Children's Special Health Care Services	☐ Homeless
☐ State Medicaid Programs (your or a dependent)	

Required Information and Supporting Documentation

Valid Government-Issued Photo ID:

☐ Driver's license

Tax Documents (Submit all that apply):

☐ Most recent State and Federal Income Tax forms including Schedules C, D, E and F if filed

Proof of Income for all Household Members (Submit all that apply):

☐ Most recent three months of employer/unemployment stubs

☐ Self-Employment Worksheet (available online at Riverview.org/financial-assistance)

☐ Supporting documentation for all additional sources of income (e.g., SSI, IRAs, annuities, etc.) for most recent three months

☐ Bank statements for most recent three months

☐ Court documents if applicable

If an applicant does not have any of the listed documents to prove income, he or she may call the Patient Accounts department to discuss other evidence that may be provided to demonstrate eligibility.

Application Certification:

I certify that the information in this application is true and correct to the best of my knowledge. I understand that Riverview Health may verify the information provided, and I authorize Riverview Health to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information or withhold relevant information, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed and I will be responsible for the balance.

_____ _____

Guarantor Signature Date

Submit completed applications:

In person or by mail
Riverview Health Patient Accounts
Attn: Financial Counselor
395 Westfield Rd
Noblesville, IN 46060

Need Assistance?

If you have questions about or need assistance to complete this application process, please contact the Patient Accounts department at 317.776.7141
8 a.m. to 4 p.m. Monday through Friday.