Financial Assistance Application

COMPLETE THIS FORM WITHIN 30 DAYS OF NOTIFICATION. FAILURE TO DO SO IS CAUSE FOR DENIAL. YOU WILL RECEIVE WRITTEN NOTIFICATION OF APPROVAL OR DENIAL. PLEASE CONTACT THE BUSINESS OFFICE AT (812) 847-5208 WITH QUESTIONS.

GUARANTOR INFORMATION *(Responsible Party)*

_____
Date

_____ _____
Name (Last, First, Middle Initial) Social Security Number

_____
Street Address, City, State, and Zip Code

_____ _____ _____
Primary Phone Number Alternate Phone Number E-Mail Address

DEPENDENTS *(Include spouse. List each separately.)*

Name (Last, First, Middle Initial)	Relationship	Date of Birth (mm/dd/yyyy)	Social Security Number

HOUSEHOLD INCOME *(Include all income from all persons living in household. You must provide yearly proof of income with this form, such as a current pay stub. If submitting before March, your W2 from the previous year will be accepted.)*

_____
Employer 1

_____
Employer 2

_____
Other Income

OTHER INFORMATION

Have you applied for Medicaid? YES____ NO____
Is there any other party or insurance that may be liable for your medical expenses? YES____ NO____
If yes, please list the insurance or other liable party:

_____

STATEMENT

I attest that the information and all statements contained in this Financial Assessment are correct and complete. I authorize Greene County General Hospital to verify any information contained herein. I understand that untrue or incomplete information is cause for denial.

_____ _____

Patient or Responsible Party Date

FOR ADMINISTRATIVE USE ONLY

Date Received: _____

Verification: Pay Stub ____ IRS Form W-2 ____ Form 1040 ____

Employer Statement ____

Other:

_____

_____

Approved ____ Denied ____

_____ _____

Signature of Financial Director Date

_____ _____

Signature of Executive Director Date