



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

_____ Name (Last, First, Middle Initial)

_____ Relationship

_____ Date of Birth (mm/dd/yyyy)

_____ Social Security Number

_____ Name (Last, First, Middle Initial)

_____ Relationship

_____ Date of Birth (mm/dd/yyyy)

_____ Social Security Number

_____ 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