Major Health Partners
Patient Financial Assistance Application
Telephone: (317) 421-5717
Fax: (317) 825-5302

Please return to:
Patient Advocate Services
2451 Intelliplex Drive
Shelbyville, IN 46176

Patient Name: _____ Date of Birth: _____ SSN : _____

Patient Account #(s) : _____ Account(s) Balance:$ _____

Address: _____

Home Phone:_____Work Phone:_____Cell Phone: _____

Spouse Name/Guarantor Name: _____ Date of Birth: _____ SSN :_____

List all dependents in the household:

Name	Date of Birth	Age	Relationship to Patient

Are you currently receiving food stamp assistance? ____ Yes ____ No

Have you applied for Medicaid benefits? ____ Yes ____ No If yes, Date applied: _____

Have you been denied for Medicaid benefits in the last 12-months? ____ Yes ____ No

If yes, reason for denial: _____

Have you applied for the Healthy Indiana Plan (HIP)? ____ Yes ____ No If yes, Date applied: _____

Total Income for Household per Month: $_____

Patient or Guarantor's Current Employer: _____

Job Title: _____ Earnings per Week: $ _____

Date this employment began: _____

If not currently working, date/location of last employment:_____

Name of Spouse's Current Employer: _____

Job Title: _____ Earnings per Week: $ _____

Date this employment began: _____

If not currently working, date/location of last employment:_____

Additional Sources of Income: List any that apply.

	Monthly Amount
Social Security Incom	$
Unemployment Incom	$
Pension	$
Veterans Benefit	$
Child Support or Alimor	$
Income from Roommate/Rental proper	$
Other income (explain	$

Do you own your home? Yes ____ No ____ Estimated value of home. $_____

Checking Account Balance: $_____ Savings Account Balance: $_____

Other Asset Balance(s): $_____ (CDs, Stocks, Bonds, etc.)

Monthly Expenses: List any that apply.

Rent / Mortgag	$	Credit Card	$
Utilities	$	Food	$
Auto Paymen	$	Child Car	$
Auto Insuranc	$	Medical Expense	$
Telephone / Cel	$	Pharmacy Expense	$
Gas	$	Other	$
Other	$	Other	$

Total All Monthly Expenses: $_____

Income Verification: Validation of current income level is required to process the application.
Please attach at least one of the items listed below for each source of income listed on the application.

- **Past two payment stubs**
- **Tax returns from the most recent year**
- **Letter from the employer(s) verifying wage amount**
- **A copy of the last check received for Social Security income**
- **A letter from the Social Security agency indicating the amount awarded**
- **W-2 statement from the most recent year**
- **Unemployment Compensation Form**

Additional Information to Support Need for Assistance: _____

_____

_____

_____

I hereby certify that the answers given are true to the best of my knowledge. I also acknowledge that completion of this form does not guarantee what action may or may not be taken to collect my account in full.

Date: _____ Patient or Account Guarantor Signature: _____

Date: _____ Spouse Signature: _____