



Dear Patient,

Application Instructions

If you wish to apply for the Providence Health Services Financial Assistance Program, please complete and return the attached Application. If you have any questions, a Financial Assistance Representative can assist you by calling 800-566-5050.

ELIGIBILITY

In order to qualify for Financial Assistance, please note the following:

- An Application for local, state, or federal aid may be required.
- **Household income must be verified. Please provide proof of household income. (Tax return and/or recent pay stubs) If you have no income, please provide a statement explaining how you are supported financially.**
- Other income sources must also be reported and include: child support, alimony, workers compensation, public assistance, self-employment income, and unemployment income.

Financial Assistance is not available for:

- Personal items, such as television expenses.
- Service that is not medically necessary including cosmetic procedures and infertility treatments
- Service covered by insurance in another health care network.
- Over-the-counter pharmaceutical items.

Determination of Financial Assistance shall only be applicable to the episode of care for which this Application is being completed.

Mail completed application and documentation to:

NRSC Financial Assistance Representative
10330 N. Meridian Street, 2N PFS
Indianapolis, Indiana 46290

Fax completed application and documentation to:

(317) 583-2753 Attn: NRSC Financial Assistance Representative

If you have any questions please contact our Customer Service Center at 800-566-5050 Monday through Friday 8:00 AM – 1:45 PM & 2:30 PM – 4:00 PM EST.



FINANCIAL ASSISTANCE APPLICATION

PATIENT INFORMATION (PLEASE PRINT)					Account No.	
Patient Name:	Birth Date	Marital Status	Sex		Telephone No.	
Address:	City	State	Zip	Email Address		
Social Security Number:	Employer		Full Time		How many hrs/wk	
			Part Time			
Employer Address:	City	State	Zip	Telephone No.		

RESPONSIBLE PARTY'S INFORMATION						
Name	Birth Date	Marital Status	Sex		Telephone No.	
Same as above						
Address		State	Zip	Email Address		
Social Security Number	Employer		Full Time		How many hrs/wk	
			Part Time			
Employer Address	City	State	Zip	Telephone No.		

RESPONSIBLE PARTY SPOUSE INFORMATION						
Spouse's Name			Social Security Number		Birth Date	
Spouse's Employer:			Address:		City	State Zip
					Telephone No.	

DEPENDENTS:					
Name	Age	Relationship	Name	Age	Relationship

GROSS MONTHLY INCOME			MONTHLY LIVING EXPENSES	Payment	Balance
Applicant Earned Income			Mortgage/Rent		
Applicant Spouse's Income			Electricity		
Social Security Benefits			Gas		
Pension/Retirement Income			Telephone		
Unemployment Compensation			Water		
Worker's Compensation			Groceries		
Interest / Dividend Income			Cable TV		
Child Support			Car Payment		
Alimony			Cell Phone		
Rental Property Income			Day Care		
Food Stamps			Child Support/Alimony		
Other			Prescription Drugs		
Other			Credit Cards:		
TOTAL GROSS INCOME:			1.		
			2.		
			3.		
ASSETS			Other Doctor /		
Cash on Hand			Hospital Bills:		
Savings Account					
Checking Account					
C.D.'s					
Securities					
Life Insurance					
Other Real Estate					
Other			Insurance Expense:		
Vehicle / Make & Model:	Year	Value	1. Automobile		
			2. Property		
			3. Medical / Life		
			Other Loan Payments:		
			1.		
			2.		
Financial Settlements:			Other Monthly Payments:		
Life Insurance			cobra		
Inheritance			life insurance		
Other			3.		
TOTAL VALUE OF ASSETS:			TOTAL MONTHLY EXPENSES:		

COMMENTS: _____

I hereby certify that the above information is true and complete to the best of my knowledge. I hereby authorize the hospital to obtain information from external credit reporting agencies if the hospital deems necessary.

Date

Signature of Patient, Spouse, Guarantor or Legal Representative

PROVIDENCE HEALTH SERVICES
FINANCIAL ASSISTANCE APPLICATION

CERTIFICATION

My signature on this form certifies that all the statements are true to the best of my knowledge and that I have disclosed all facts concerning my finances. I understand and acknowledge that any misrepresentation of my finances in connection with this Application, or any failure to cooperate with efforts to qualify me for programs which may cover the cost of my care (for example, Medicaid, personal injury claim, workmen’s compensation) may invalidate any award of Financial Assistance and that I will be financially liable for the services provided. I agree to allow Providence Health Services or its representatives to request and review a report of my credit and to take other reasonable steps to validate all information provided.

I understand that if I qualify for partial financial assistance I will be responsible for payment of the remaining portion of my bill.

Statement Regarding Gross income (before taxes and withholding)

My Total Yearly Household Income (add the Patient and Spouse Yearly Columns from other side and write the total below):

Statement Regarding Lack of Income

Briefly describe your financial/living situation and why you need financial assistance with your medical bill(s).

Please Sign Below:

Patient /Guardian

(Date)