Financial Assistance Application

To be considered for financial assistance, please complete both pages of the enclosed application, and include requested proof of income documents that apply to you listed in the "Income" section. **All applicants are required to apply for Medicaid and meet all required Medicaid documentation in order to be considered for the FAP.** If after you submit the application CMCH determines more information is needed, you will receive a letter with the details describing what is needed. You will be notified in writing of our decision within 30 business days of CMCH receiving the completed application. The program covers emergent and medically necessary services provided by CMCH. The program may or may not cover medical bills you may have with other providers; please contact them directly to see what financial assistance programs they may have to offer. Court costs, filing fees, interest and attorney fees from one of our collection agencies are not covered or paid by this program.

If you have any questions about the application or need assistance completing it, contact the CMCH Patient Financial Services Department at 260-667-5513.

Please return the completed application in the envelope provided to:

Cameron Memorial Community Hospital
Attn: Patient Financial Services
416 E. Maumee Street Angola, IN 46703

Section One: Patient Information

Please complete all of the below information regarding demographics and insurance information

Account Number: ______________________________ Service Dates: ____

Name:____

Address: ________________________________ City: ___________________ County: _______________Date of Birth: ______________________

State: _________ Zip Code: _________ Social Security Number: ___________________________Civil Status: Single ____Married _____Divorced

Home Phone: __________________________ Cell Phone: _____________________________

Are you a legal resident of the United States? ______Yes_______ No

Employer Name: ____ ☐ Patient ☐ Spouse ☐ Other

Employer Name: ____ ☐ Patient ☐ Spouse ☐ Other

Did you have health insurance (other than Medicaid) at the time of health care? If yes, please write down your account information and include a photocopy of your insurance card. If you didn't, could you access your insurance at the time of service?

Name of insurer: ____ Date of entry into force: _________________________

Subscriber Name: ____ Subscriber ID Number: __________________________

Group number: ____________________________________

Section Two: Your Home

Please provide the information below to any immediate family member who lives with you within your home.
In this case, the family is the patient's husband and the patient's children (biological or adopted; who are under 18 years of age.

If the patient is under 18 years of age, include the patient's name, the patient's parents (biological or adoptive), and children (biological or adoptive, who are under 18 years of age) of the parents living in the home.

Family Member Name(s)	Date of Birth	Relation with the patient
1.		
2.		
3.		
4.		
5.		

CAMERON
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Section Three: Income

Source of income	Current monthly gross patient income	Spouse/other current monthly gross income	Total monthly family income	Proof of payment (corresponding to applicable remedies)
Fees	$	$	$	Most recent pay stubs that prove your income this year to date (at least 4 weeks of previous income) or a signed employment verification letter from your employer
Self-employment	$	$	$	Copy of previous year's personal and business tax return along with any payment schedule
Child support or alimony	$	$	$	Copy of current court-issued documentation or printed confirmation from an *amicus curiae*
Social security/pensions	$	$	$	Copy of letter declaring receipt of the benefit or a bank statement checking deposits
Dividends, interest, rental income	$	$	$	Dividend/interest check Proof of rental income
Unemployment insurance, workers' compensation	$	$	$	Unemployment insurance check stub or proof of worker's compensation
Veterans Benefits	$	$	$	Veterans benefit letter
Other income	$	$	$	Bank statement checking other income (education income, miscellaneous income, etc.)
Total	$	$	$	

If there is no income, please describe in a few words how the basic needs of life are met, also noting who is supporting it.

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Section Four: Assets

Asset Type	Current Balance for Patient	Current Balance for Spouse/Other
Bank Account – Savings	$ ____________	$ ____________
Bank Account – Checking	$ ____________	$ ____________
Stocks, Bonds, Funds	$ ____________	$ ____________
HSA/FSA Account	$ ____________	$ ____________
TOTAL	$ ____________	$ ____________

Section Five: Expenses

Note that residual income is determined based on income and expenses.
Be sure to consider any monthly expenses for purposes of this application.

	Monthly spending
Accommodation (rent, mortgage, etc.)	$ ______________________
Auto	$______________________
Insurance	$ ______________________
Utilities (gas, electricity, water)	$ ______________________
Health insurance	$______________________
Health care	$ ______________________
Fuel	$ ______________________
Household Expenses	$ ______________________
Credit cards	$ ______________________
Cell Phone	$ ______________________
Landline	$______________________
Cable TV	$ ______________________
Other (specify)	$ ______________________
Other (specify)	$ ______________________

Section Six: Certification

I understand that the information I provide to CMCH will be subject to verification. If necessary, I give CMCH permission to access my credit history. I also understand that CMCH may ask me for more information, if necessary to determine my eligibility, e.g. proof of assets, bank statements, HSA statements, or a denial letter issued by Medicaid. This request may be denied if I do not submit the required documentation, reserve the right to reverse any adjustment if any payment is released.

I have read this application carefully and all the information I have represented is accurate and true.

Signature of Financial Officer: _________________________________Date: ____

Relationship with the patient (if not self): ____