

Use **BLACK** ink only

FINANCIAL ASSISTANCE APPLICATION

Please complete the application to the best of your ability and as fully as possible and return within ten working days. This will help us answer your request as quickly as possible. If you would like to provide additional information of any kind that you feel will help us better understand your situation, please attach a letter to this application. Any questions, call 812-450-6815.

YOU MUST ALSO PROVIDE PROOF OF GROSS HOUSEHOLD INCOME. THIS MAY BE IN THE FORM OF:

- 1. LAST FOUR (4) PAY STUBS
- 2. LAST YEAR'S FEDERAL (1040) TAX RETURN AND ANY ATTACHED SCHEDULES
- 3. SOCIAL SECURITY INCOME AWARD LETTER OR 1099 (NO BANK STATEMENTS)

PATIENT INFORMATION (PLEASE PRINT)

	Patient Name				Birth Dat	е	Age		Marital M S			Sex M F		Telephone No.	
	Street Address					City		•				State		Zip Code	
	Social Security Number	Occup	oation		Employe	r				How long?	•	F1 P1		How many hrs/wk?	
	Employer Address				City			5	State	_	Zip (Code		Telephone No.	
F	RESPONSIBLE PARTY'S	INFORM	ATION				Email:								
N	ame			В	irth Date		Age		Marital M S			Sex M F		Telephone No.	
A	ddress			,		City	1	. I				State		Zip Code	
S	ocial Security Number	Occupati	on	E	mployer				Hov		•	FT PT		How many hrs/wk?	
E	mployer Address			С	ity			5	State		Zip (Code		Telephone No.	
F	RESPONSIBLE PARTY S	POUSE IN	IFORM	ATION											
S	pouse's Name								E	Birth D	ate			Sex M F	
S	ocial Security Number	Occupati	on	E	mployer				Hor			FT [PT [How many hrs/wk?	
E	mployer Address			С	ity			Stat	е	Zi	р Сос	de	Tel	ephone No.	
	DEPENDENTS (Anyone	living in h	ouseho	old)											
	Name		Age	F	Relation		1	Name)		Age			Relation	
	1.					5.									
	2.					6.									
	3.					7.									
	4.					8.									

ASSETS	dollar amount:	DEBTS	dollar amount:
Cash on Hand		Home Loan Balance	
Savings Account		Car Loan Balance	
Checking Account		Credit Card Balances:	
C.D.'s		1.	
Securities		2.	
Life Insurance		3.	
Home Value		Other Debts:	
Other Real Estate		Other Debts.	
Other Cear Estate Other			
_			
TOTAL			
Vehicle Information			
Make Year	Value		
1.		TOTAL	
2.		MONTHLY PAYMENTS	
3.		Mortgage (PITI)	
		Rent	
GROSS MONTHLY INCOME (Need pr	oof of Income)	Electric	
Applicant		Gas	
Applicant Spouse		Telephone / Cell Phone	
Social Security		Water	
V.A. Pension		Cable	
Pension		Food	
Unemployment		Furniture	
Worker's Compensation		Car Payment	
Interest Income		Clothing	
Dividend Income		Day Care	
Child Support		Child Support	
Alimony		Alimony	
Income from Rental Property		Credit Cards:	
Food Stamps		1.	
Other		2.	
Other		3.	
TOTAL		Payments on Medical Bills:	
		2.	
FINANCIAL SETTLEMENTS		7 3.	
Insurance		4.	
Inheritance			
Other		Insurance: Auto	
TOTAL			
		Property Medical	
Comments:			
		Loan Payments:	
		1	
		- -	
		TOTAL	
I, (your name)	, do sol	emnly state that the information contained on the	is application is true and
accurate to the best of my knowledge and	belief. You are authorized t	emnly state that the information contained on the to check my credit and employment history.	
Date		Signature of Patient, Parent, Spouse or L	egal Representative
Duit	•	orgridiano or rationity ranolity opouse of L	ogai nopiosoniulivo