WITHAM HEALTH SERVICES

Small Hospital. Big Medicine.

Patient Accounts
2605 North Lebanon Street
Lebanon, IN 46052
765-485-8060
Fax 765-485-8069
www.witham.org

Dear Customer:

Thank you for using Witham Health Services for your healthcare needs.
Per your request, attached is an application for Financial Assistance.

In addition to completing the enclosed application, the following income information listed below is required for anyone 18 or older (and not a high school student) who lives in the household.
We cannot process your application until we receive ALL the following documents that are applicable to anyone listed on the application:

- ☐ Federal Tax Return form(s): (1040, 1040A, or 1040EZ) including all schedules
- ☐ W-2(s) and/or 1099(s)
- ☐ Paystubs: a copy of most recent
- ☐ Bank statements: a copy of the three (3) most recent
- ☐ SSI / SSA / Pension: copy of actual check, bank statement, or Social Security document
- ☐ Wage Inquiry: for Non-working (proof of $0 income) or Unemployment benefits:
  A Wage Inquiry may be obtained through Witham Patient Accounts.

Please return your application and required documentation to Patient Accounts at Witham. You can drop them off directly at Patient Accounts, mail or fax:
Mail: Witham Health Services Attn: Patient Accounts PO Box 1200 Lebanon, IN 46052
Fax: 765-485-8069

If you do not qualify for financial assistance, we also offer payment plan options. If you have any questions regarding this letter or your accounts, contact Witham Patient accounts at 765-485-8060.

- **Medicaid / HIP eligibility screening**: If you or a family member does not have insurance you may be requested to contact **ClaimAid** to be screened for Medicaid or HIP eligibility. You may contact ClaimAid directly at (765) 485-8195. They are located in the main registration area of Witham Hospital. ClaimAid is generally available Monday–Friday 8 a.m.–4 p.m. by appointment, also takes walk-ins if no appointments are scheduled at that time.

Thank you again for choosing Witham Health Services.

Sincerely,

Patient Accounts

Witham Health Services
Financial Assistance Application

Witham Health Services
2605 N. Lebanon Street
Lebanon, IN 46052
765-485-8060
Fax 765-485-8069

_____ _____

Last Name *First Name* *Middle Initial*

_____

Address

_____ _____ _____

City *State* *Zip Code*

_____ _____

Home/Cell Phone # *Work/Cell Phone #*

_____

Email (optional)

1. Have you applied for Financial Assistance in the last 12 months? ☐ Yes ☐ No
2. Do you have Health Insurance? ☐ Yes ☐ No
   a. Child/Children? ☐ Yes ☐ No
   b. Spouse? ☐ Yes ☐ No
3. If you do not have insurance, have you applied for Medicaid/HIP in the last 60 days? ☐ Yes ☐ No
4. Are you a member of a Cost Sharing Ministry program? ☐ Yes ☐ No

Names of all household members	Date of Birth	Social Security #	Relationship	Age
1. Applicant			Self	
2.				
3.				
4.				
5.				
6.				
7.				
8.				

(If more than 8 please add under comment section, next page)

I would like to request a review of my application for the Financial Assistance program. I certify that the information is subject to verification by Witham Memorial Hospital and hereby authorize any holder of the information supplied in this application to release such information to Witham Memorial Hospital for purposes of this application for Financial Assistance. I also authorize Witham Memorial Hospital to check my credit history through the credit bureau, if deemed appropriate. I further understand that failure to disclose information requested in this application or disclosure of erroneous information could cause the application to be denied.

_____ _____

Signature *Date*

Office Use Only

Documents needed: _____

Comments: _____

Application Complete: _____

MONTHLY INCOME	AMOUNT	MONTHLY EXPENSES	AMOUNT
Wages (gross)	$	*Rent/Mortgage	$
SSI, SSA, and/or Pension	$	2nd Mortgage or Rental Property	$
Unemployment	$	Utilities (Gas, Electric, Water)	$
Child Support Received	$	Telephone/Cell Phone	$
Rental Property Income	$	Cable/Satellite	$
Roomers/Boarders	$	Child Support Payment	$
Paid Cash for Work	$	Vehicle Payment	$
Other:	$	2nd Vehicle Payment	$
TOTAL MONTHLY INCOME:	**$**	Insurance – Auto	$
		Insurance – Home/Life	$
OTHER INCOME LAST 12 MONTHS		Insurance – Medical (do not include if payroll deducted)	$
Lawsuit Settlements	$	Pharmacy – Monthly	$
Settlement Month/Year	/	Medical Payments – Monthly	$
Pending?		Food – Misc. Items	$
Inheritance/Lump Sum	$	Gas – Auto Fuel	$
TOTAL OTHER INCOME:	**$**	Daycare	$
		Student Loan	$
		Other:	$
		TOTAL MONTHLY EXPENSES:	**$**

ASSETS	AMOUNT	LIABILITIES	AMOUNT
Value of Residence	$	Mortgage Loan Balance	$
Value of Rental Property	$	Rental Property Loan Balance	$
Checking Account Balance	$	Credit Card(s) Balance	$
Savings Account Balance	$	Auto Loan Balance	$
401K / IRA / Investments	$	Medical Bill(s)	$
Other:	$	Student Loan Balance	$
		Other:	$
TOTAL VALUE ASSETS:	**$**	**TOTAL LIABILITIES:**	**$**

1. If you do not own or rent your home, please indicate if staying with Relative/Friend/or Other:
2. If financial or family situation has changed since prior year taxes, please give brief description of situation under comments.
3. If no income or resources, please explain under comments how paying expenses or providing basic needs to live.

COMMENTS:

SELF EMPLOYMENT ONLY

LAST 3 MONTHS	BUSINESS INCOME	BUSINESS EXPENSES	NET INCOME
1 Month Ago	$	$	$
2 Months Ago	$	$	$
3 Months Ago	$	$	$
TOTALS:	**$**	**$**	**$**
		ESTIMATED AVERAGE NET INCOME LAST 12 MONTHS:	**$**