



FINANCIAL DOCUMENTATION REQUIRED FOR ALL  
MEMBERS OF THE HOUSEHOLD

Date: \_\_\_\_\_

Dear Patient,

In an effort to assist you with your medical expenses at Harrison County Hospital, an application for financial assistance is enclosed. Please **complete the application** and **provide copies** of the documentation checked below.

**You may be contacted by a representative from an outside agency (ClaimAid or Complete Billing Services) who work with the hospital, to see if you are eligible for other payment sources that may be available. Failure to cooperate with one of these outside agencies will result in a denial of financial assistance.**

**For the application to be considered, you MUST return the following documents:**  
***(Your application cannot be processed for consideration if the requested documentation is not included.)***

☒ **Food Stamps or TANF** ***\*If you provide proof of current eligibility for Food Stamps or TANF you do not need to provide any other documentation other than the proof of eligibility letter and filled out application form.\****

☐ **Federal Tax Return (1040) for the most recent year (or IRS Form 4506-T).**

☒ **Last Three Months of Financial Information:**  
***(Checking, Savings and Investments - please include all pages of each statement)***

☐ **Pay Stubs for the last 13 weeks for patient and spouse (or last 7 bi-weekly pay stubs), if income has changed since previous year's tax return.**

☐ **Proof of Any Other Income (i.e. Social Security, Child Support, Rental Income, Unemployment, Pension, Self-Employment, etc.).**

☒ **Other:** If either you or your spouse have no income then that person must submit a signed personal statement noting the date you last worked and/or the start date of disability and how primary household expenses are paid.

**Other:** \_\_\_\_\_

Please return materials **by mail or fax (812) 738-8780** within 10 days or call me **to schedule an appointment to copy and review** the information. If you have any questions, please feel free to call me **at (812) 738-7846**.

Thank you,

**Stephanie Lovings**  
**Financial Counselor**

1141 Hospital Drive NW • Corydon, IN 47112 • (812) 738-7846 • (800) 447-4251 ext. 2230 • Fax: (812) 738-8780

**APPLICATION FOR FINANCIAL ASSISTANCE**

ACCOUNT # \_\_\_\_\_

I hereby request that Harrison County Hospital make a written determination of my eligibility for financial assistance services. I understand that the information, which I submit concerning my annual income and family size, is subject to verification by this Hospital. I also understand that if the information, which I submit, is determined to be false, such a determination will result in a denial of financial assistance and that I will be liable for charges for services provided.

**PLEASE PRINT****1. GUARANTOR (person responsible for payment)**

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_  
                     Last                      First                      MI  
 Address: \_\_\_\_\_ Phone #(\_\_\_\_)\_\_\_\_\_  
                     Number and Street                      City                      State                      Zip  
 County: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

**2. EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_**

Address: \_\_\_\_\_ Phone #(\_\_\_\_)\_\_\_\_\_  
                     Number and Street                      City                      State                      Zip

**3. PATIENT'S information if different than Guarantor**

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_  
                     Last                      First                      MI  
 Address: \_\_\_\_\_ Phone #(\_\_\_\_)\_\_\_\_\_  
                     Number and Street                      City                      State                      Zip

**4. PATIENT'S Spouse**

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_  
                     Last                      First                      MI  
 Address: \_\_\_\_\_ Phone #(\_\_\_\_)\_\_\_\_\_  
                     Number and Street                      City                      State                      Zip

SPOUSE'S EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

5. Has guarantor filed bankruptcy in the last 12 months?    Yes        No

6. FAMILY SIZE \_\_\_\_\_ (All persons claimed on tax return)

7. INCOME: List income for all the family members claimed on your tax return. *Attach proof of the supporting income*

| NAME | RELATIONSHIP | AGE | NAME | RELATIONSHIP | AGE |
|------|--------------|-----|------|--------------|-----|
| 1.   |              |     | 5.   |              |     |
| 2.   |              |     | 6.   |              |     |
| 3.   |              |     | 7.   |              |     |
| 4.   |              |     | 8.   |              |     |

|    |  |  |    |  |  |
|----|--|--|----|--|--|
| 1. |  |  | 5. |  |  |
| 2. |  |  | 6. |  |  |
| 3. |  |  | 7. |  |  |
| 4. |  |  | 8. |  |  |

**8. TOTAL AMT. FOR LAST 13 WEEKS**

|                                            |    |       |
|--------------------------------------------|----|-------|
| Gross Wage                                 | \$ | _____ |
| Self-Employment or Personal                | \$ | _____ |
| TANF Benefits                              | \$ | _____ |
| Food Stamps Benefits                       | \$ | _____ |
| Social Security/Disability                 | \$ | _____ |
| Unemployment Compensation                  | \$ | _____ |
| Worker's Compensation                      | \$ | _____ |
| Child Support                              | \$ | _____ |
| Pensions                                   | \$ | _____ |
| Income from Dividends, Interest, or Rental | \$ | _____ |
| Other (Please Explain)                     | \$ | _____ |

**TOTALS \$** \_\_\_\_\_

**9. ASSETS** (please provide copies for last 3 months)

\$ \_\_\_\_\_ Checking Acct Balance

Financial Institution Name: \_\_\_\_\_

\$ \_\_\_\_\_ Saving Acct Balance

Institution Name: \_\_\_\_\_

\$ \_\_\_\_\_ Investments (Stocks, Bonds, Mutual Funds, Money Market Account(s), CD's)

\$ \_\_\_\_\_ Other Assets (please describe)

\$ \_\_\_\_\_ **TOTAL ASSETS**

**FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA FOR HOSPITAL**

**Based upon Federal Poverty Guidelines, Gross income levels, 2026**

| Family Size     | 100%      | 75%             |
|-----------------|-----------|-----------------|
| 1               | 0-31,920  | 31,921-47,880   |
| 2               | 0-43,280  | 43,281-64,920   |
| 3               | 0-54,640  | 54,641-81,960   |
| 4               | 0-66,000  | 66,001-99,000   |
| 5               | 0-77,360  | 77,361-116,040  |
| 6               | 0-88,720  | 88,721-133,080  |
| 7               | 0-100,080 | 100,081-150,120 |
| 8               | 0-111,440 | 111,441-167,160 |
| Each Additional | 11,360    | 17,040          |

If you would like a copy of the Financial Assistance Policy go to [WWW.HCHIN.ORG](http://WWW.HCHIN.ORG) or call (812) 738-7846.

## **AUTHORIZATION TO RELEASE INFORMATION**

**The undersigned certifies the following:**

- 1. Patient and/or guardian has applied for financial assistance with Harrison County Hospital and as part of the application process, it is understood that Harrison County Hospital may verify information contained in patient and/ or responsible party's application and in other documents such as the patient's credit report which may have been supplied in connection with the financial assistance application.**
- 2. Patient and/or responsible party duly authorize you to release and provide to Harrison County Hospital any and all information and documentation that they may request. I give permission to Harrison County Hospital to discuss any accounts that are in the patient and/or guardian's name.**
- 3. A photo or faxed copy of this authorization may be accepted as an original.**

\_\_\_\_\_  
**Printed Patient's or Responsible Party Name**

\_\_\_\_\_  
**Patient's or Responsible Party Signature**

\_\_\_\_\_  
**Social Security Number**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Spouse/Other's Name**

\_\_\_\_\_  
**Spouse/Other's Signature**

\_\_\_\_\_  
**Social Security Number**

\_\_\_\_\_  
**Date**

**I understand that the information which I submit is subject to verification by Hospital. I certify that the above information is true, correct, and complete.**