Goshen Physicians

Financial Assistance Required Documentation

Along with your application, please include copies of current documentation for the following members living in the household: patient, patient's spouse, patient guarantors, patient's parents, grandparents, in-laws and any children and/or siblings over the age of 18. Separated couples must provide legal proof of separation or spouse's income/signature will be required. If the patient is a college student living on campus, please note we will require parent's household size and income information.

1. All household income (If applicable):

a. Paystubs-last 4 consecutive paystubs, if paid weekly or 2, if paid bi-weekly, etc.
b. Documentation for-current year of Social Security award letter, child support, TANF, unemployment, pension or any other source of income received in the last 30 days.
c. If self-employed, please provide most recent tax return, including all pages of Schedules.
d. We require a Wage History Report from the Work One office for a patient or family member over the age of 18 with no income. Please provide the "Release of Information" for us to obtain the report, along with a copy of a state identification. If unemployed within the last 30 days, please provide a letter from the previous employer stating termination date.
e. If the patient has no earned income, we require a support statement from the person providing financial support to the patient, signed by both the patient and supporter.
f. If a household member, over the age of 18, is a full time high school or college student, and is not receiving income, please provide current semester class schedule.
g. If a patient has a valid financial determination letter from a Federally Qualified Health Center (Maple City, Vista), we will accept this determination in place of items #1 and #2.

2. All pages and transactions of household bank statements:

a. Savings, Checking and/or Pre-paid card for the last 30 days
b. Certificates of deposits, Money Market accounts, stock and/or bonds and Retirement account statements

3. Proof of current residency, with the patient or guarantors name and address. Please choose one of the following:

a. Any type of statement, not from Goshen Hospital, paystub or bank statement can be used as proof of residency
b. Current Landlord contract, letter from landlord or mortgage statement

4. Other information, if applicable:

a. If uninsured at the time of service, we may require patient to apply and comply with government insurance.
b. If insured at the time of service but insurance card was not available, please provide front and back copies of the card.
c. If the patient and/or immediate family member are self-employed and do not file taxes, please provide statements from the customers in the last 30 days, including name, contact information and amount paid.
d. If a patient has a valid financial determination letter from a Federally Qualified Health Center (Maple City, Vista), we will not require the patient/guarantor to apply and comply with government insurance for non-emergent services.

All information is required in order to process your request for assistance. Upon review of your application, additional documentation may be required. Please be aware that you must have exhausted all other forms of payment in order to qualify for assistance. **Failure to provide the required documents will result in denial of your application. Financial Assistance applications are valid for 1 year from date of signature.**

Your application and all documents are due back by: _____

Please mail, fax, or bring your application and documentation to:

Goshen Physicians CPO
Attn: PFS
PO Box 834
Goshen, IN 46527
Fax (574) 364-2942

If you have any questions, Financial Advocates are located near the Main Lobby in our facility: (574) 364-2607 or for Spanish speakers: (574) 364-2975. To access of our Financial Assistance Policy, Financial Assistance Summary and Financial Assistance application please visit our website at goshenhospitalfinancialassistance.com

You will be notified by mail within 3-4 weeks to inform you of the decision made regarding your application.

Updated 09/27/19 **Continue-->**

Financial Assistance FAQ's.

If you send the requested documents to us by fax, we receive them sooner than by mail. Please **send copies and not originals**. Please do not send using both methods as this may delay the process.

Please note: if all documents are not submitted, the application will be denied and a letter will be sent to you stating what was missing.

The Financial Assistance process takes about 4 weeks to process from the date of receipt of all documents. If your account is still out to insurance, please allow additional time to complete the process as we must wait until your insurance processes your claim(s).

If you have a new service/account, please contact our office to check if the application is still valid to apply the current assistance amount.

Please note, if you have a large number of accounts, you may receive more than one letter regarding Financial Assistance. Please keep track of your accounts/statements and match them to the determination letter(s).

If you are a patient from a Federally Qualified Health Center who received assistance from a FQHC, please provide a letter from the facility stating the level of assistance you received.

1. **I have submitted my application, what do I do now?**
   - ✓ If your application is complete and insurance has paid their portion, please allow up to 4 weeks to process.
2. **Do I have to make a payment while my application is being evaluated?**
   - ✓ No. We ask that you do not make any payments on the current accounts that are being evaluated.
3. **What if the account goes to collections while my application is being evaluated?**
   - ✓ We place your accounts on hold so they do not follow the collections process.
4. **My application was denied because I did not submit the appropriate documents. Can I re-apply?**
   - ✓ You may still continue with the assistance if you submit the appropriate documents and if you are within the timeline allowed to apply. There is no need to resubmit another application. Please write the patients name and account number on each item you send.
5. **My account has already gone to collections. Can I still apply for Financial Assistance?**
   - ✓ If it is within 240 days from the first statement which was sent out, then yes. It if has been longer than 240 days, we cannot provide assistance. Please note, if we grant assistance on an account that has already gone to collections, the account will remain open at the collections agency until a determination has been made. We will adjust the original balance if assistance is applied and will forward the information to the agency.
6. **I have multiple accounts and will continue to have services. Will all my accounts be combined?**
   - ✓ No. We do assistance on the accounts that have been processed by insurance. It is your responsibility to contact us within 10 days of the dated letter to set up a payment plan on any remaining balance(s).
7. **Does Financial Assistance cover my bills from the physician, Radiology Inc., APOGEE, Gerig Surgical and other outside providers?**
   - ✓ No. Please contact each provider to inquire on financial assistance options for their bills.
8. **I already made a few payments on my account. Will that be refunded to me?**
   - ✓ We will take your payments into consideration while evaluating the assistance and will refund if appropriate.
9. **Do I need to fill out an application for each of my family members?**
   - ✓ If you have questions about this, please call our office as situations may vary.

10. I have already submitted an application but I continue to receive statements and late fees are being added.

- ✓ When we receive a complete application, we place your accounts on hold so they do not continue the collection process. However, the statements are automatically generated, so we are not able to put a hold on those. If late fees are added, we will remove them once we determine the level of assistance approved.

Updated 08/12/16

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Goshen Physicians

This application will be evaluated to determine if you qualify for financial assistance. Fill it out as thoroughly as possible. If you are applying on behalf of someone else, please answer questions using the patient's information. If a question does not apply to you, please write "N/A."

Patient Information

Application for Financial Assistance

Account Number(s): _____

First Name _____ Last Name _____ MI _____

Social Security Number _____ Date of Birth _____

Home Address _____

Mailing Address *If different _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

County Of Residence _____

Contact Phone Number _____

Household Information

Please list all people living in the household.

Name	Date of Birth	Relationship to Patient	Does the member have hospital accounts with current balances?

Income Information

Please complete this section about the ***gross*** income of each household member.

Name of Household Member	Amount	How Often	Employer Name & Phone
Name of Household Member	Amount	How Often	Employer Name & Phone
Name of Household Member	Amount	How Often	Employer Name & Phone

Other Income

Please complete this section of household members receiving income, other than an employer.

Type of Income	Amount	How Often	Name of Recipient
Social Security			
Child Support			
Unemployment			
TANF			
Rental Income			
Retirement Benefits/ Pensions			
Other (Describe)			

Do you expect a change in your income in the next 3 months? Yes/No

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Assets

Do you have any bank accounts? Yes/No

Checking Balance _____ Name of Bank

Savings Balance _____ Name of Bank

CD's _____ Name of Bank

Insurance

Does the patient have medical insurance?	Yes / No
Does the patient participate in a medical sharing plan (Such as Liberty Health Share, Samaritan Ministries, Christian Health Share)? If yes, please provide proof of payment or denial letter.	Yes / No
Has the patient applied for Medicaid/HIP within 120 days? If yes, please provide determination letter.	Yes / No
Is COBRA available to the Patient? If so, when was employment terminated?	Yes / No

Spouse/Guarantor Spouse Information

Spouse Full Name	
Social Security Number	Date of Birth

Patient Agreement

I/We hereby apply for financial support for services rendered by a Goshen Health facility. I/We certify that the information provided by me and contained hereon is true, accurate, and correct to the best of my knowledge. I hereby authorize Goshen Health and its assignees to order a consumer credit report or verify other credit information. I/We hereby give consent to Goshen Health to verify all statements made on the Financial Assistance Application.

In the event the undersigned, the patient, or any other person on the patient's behalf are entitled to receive insurance benefits because of services rendered to the patient by any Goshen Health facility, said insurance benefits are hereby assigned to Goshen Health for application against said patient's hospital bill. It is further agreed that Goshen Health or any of its facilities may issue a receipt to said insurance company for any such payment thereby releasing said insurance company from any and all obligations under the insurance policy to the extent of the payment. The undersigned and the patient, however, remain responsible for the hospital charges not covered by this assignment in the event this application for assistance is denied.

Goshen Health reserves the right to re-evaluate this application for assistance should additional information become available after a determination has been made. I/We know that anyone who makes or causes to be made false statement commits a crime punishable by law, and can be fined or jailed for fraud and/or perjury.

Patient/Guarantor Signature _____ Date _____

Patient/Guarantor Spouse Signature _____ Date _____

Support Statement

(To be completed by the person providing support if the patient has no income)
I have been identified by the applicant as providing financial support. Below is a list of services

I provide the applicant:

I hereby certify and verify that all of the above information given is true and correct to the best of my knowledge and belief. I understand that my signature will not make me financially responsible for the medical charges.

Signature: _____ Date: _____

Patient Name (from page #1): _____

Patient's living outside of Goshen Physicians' service area are not eligible for Financial Assistance. If you are unsure whether you are within our service area, please contact a Financial Advocate at 574-364-4727.

Updated 02/2021

INDIANA WORKFORCE DEVELOPMENT AND ITS WorkOne CENTERS

RELEASE OF INFORMATION

***NAME OF APPLICANT (PRINT)**_____

***SOCIAL SECURITY:** _____

***CURRENT DATE:** _____

I authorize the Indiana Department of Workforce Development to release all wage and unemployment benefit information to the agency listed below.

_____

***SIGNATURE OF APPLICANT**

☐ **Check this box if Power of Attorney is attached**

By signing below you agree that you understand that data we release to you is protected under state law (IC 22-4-19-6) and federal regulations (20 CFR § 603.5) as confidential information. You also confirm that you have verified the applicant's identity by viewing some type of photo identification.
***NOTE: RELEASE MUST BE SUBMITTED WITHIN 90 DAYS OF APPLICANT SIGNING RELEASE FORM.**

***Signature of Requestor: _____**

Requesting Agency: _____

Fax Number: _____

Phone Number: _____

***REQUIRED FIELDS: For questions email EmployVerification@dwd.IN.gov**