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 Health, 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: [redacted]

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

Goshen Physicians CPO
Attn: PFS
PO Box 834
Goshen, IN 46527
Fax (574) 364-2759

If you have any questions, please contact the Goshen Physician Billing Office at (574) 364-4727, or in person at 2120 S. Main Street Goshen, In. 46526. To access 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. **

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?**
   - ✓ Yes. We ask that you do not make payments on the current accounts that are being evaluated. Any payments made after the application has been received will be applied to other balances or refunded if there are no other balances to apply the credit to.

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 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 patient's name and account number on each item you send.

5. **My account has already gone to collections. Can I still apply for Financial Assistance?**
   - ✓ No. Once accounts for Goshen Physicians have been sent to our outside Collection Agency, they are no longer eligible for Financial Assistance.

6. **I have multiple accounts and will continue to have services. Will all my accounts be combined?**
   - ✓ No. 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. **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.

8. **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, we cannot put a hold on those. If late fees are added, we will remove them once we determine the level of assistance approved.

9. **Does Financial Assistance cover my bills from Radiology Inc, APOGEE, Gerig Surgical and other outside providers?**
   - ✓ No. Please contact each third-party vendor to inquire into financial assistance options for their bills. Financial Assistance does cover Accounts for Goshen Physician Providers.

10. **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.

Continue-->

Goshen Physicians

Updated 01/01/2026

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 other 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

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.

INDIANA DEPARTMENT OF WORKFORCE DEVELOPMENT

RELEASE OF EMPLOYMENT HISTORY

LKE INSTRUCTIONS Rev.3/1/24

The Indiana Department of Workforce Development (IDWD) will release wage or employment history information to a third party only via the Last Known Employer (LKE) website after submitting a completed copy of the attached release form. Please login to your LKE account to submit requests for employment history. If you do not have a LKE account and the reason for requesting employment history on behalf of a citizen is in compliance with IC 4-1-6-2(13)(B), you may apply for an account by navigating to https://uplink.in.gov/lke.

***Please Note:**

- **Non-IDWD forms will not be completed by IDWD staff.**
- **Unemployment insurance (UI) benefit information:** Applicants who have had an Indiana UI claim can obtain benefit information via their Claimant Self Service (CSS) account at uplink.in.gov/CSS/CSSLogon.htm. CSS support can be reached by navigating to webapps.dwd.in.gov/AskWorkOne or calling 800-891-6499.
- **Copies of IRS Form 1099-Misc:** Applicants who have had an Indiana UI claim can obtain copies via CSS of Form 1099 issued by DWD for UI payments.

Information regarding employment history available via IDWD employer Unemployment Insurance Tax records:

- **If complete wage and/or employment history records are needed**, we recommend contacting the Social Security Administration, Internal Revenue Service, or Indiana Department of Revenue.
- IDWD employer tax records **do not include wages earned** in other states or U.S. territories, income earned which was or will be reported on a 1099-Misc Form (self-employment, contract employment, etc), or income earned through the performance of non-covered or excluded services described in IC 22-4-8.
- Employers report wages to IDWD quarterly. Even timely reports are often 4-6 months in the arrears. The information IDWD has available is employer, not employee, records for the purposes of assessing an employer's Unemployment Insurance Tax **which is often not an accurate reflection of an individual's complete income or employment history.**

To avoid an automatical denial, please ensure the following action is taken when submitting a request for employment information via the LKE website:

- Use only the attached form. No other forms will be accepted or completed. Do not submit non-DWD forms.
- **Ask applicants to provide all previously used names during employment on the IDWD approved release form.**
- Confirm the form is **complete,** legible, and there are no corrected errors on the release form. If a mistake is made, please complete a new form as an error on the form could result in the request being denied.
- A **valid** Social Security Number or Individual Tax Identification Number is required.
- An **original signature** (not electronic) is required for the applicant.
- Submit only one release form per applicant request for employment history. Requests submitted with release forms belonging to multiple applicants will be denied.
- Please do not submit duplicate requests. Submitting duplicate requests delays processing times and may result in denial.
- Every effort will be made to respond to requests within 5 business days. Processing times may be longer during periods of high volume.

Thank you,

Employement History Verification Unit
Indiana Department of Workforce Development
employverification@dwd.in.gov

INDIANA DEPARTMENT OF WORKFORCE DEVELOPMENT

RELEASE OF INFORMATION

Rev. 6/1/26

***APPLICANT'S NAME:** _____

Additional names used during employment: _____

***SOCIAL SECURITY or INDIVIDUAL TAX IDENTIFICATION NUMBER:** _____-_____-_____

****Applicant contact information***

Email Address: _____ **Phone Number:** _____-_____-_____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

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

_____ _____

***SIGNATURE OF APPLICANT** ***TODAY'S DATE:**

NOTE: RELEASE MUST BE SUBMITTED WITHIN 90 DAYS OF APPLICANT SIGNING RELEASE FORM.

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

NOTE: This section must be completed by the organization requesting employment history.

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.

***SIGNATURE OF REQUESTOR:** _____

***Printed Name of the Requestor:** _____

*** Requesting Organization:** GOSHEN PHYSICIANS

***Email Address:** _____

***Phone Number:** 574-364-4727 **Fax Number:** 574-364-2759

****REQUIRED FIELDS***

*****Applicant's phone number, email address, or mailing address is required.***

Email employverification@dwd.in.gov to reach a DWD employment history or LKE website specialist.

LKE Form