Patient Financial Assistance Program

Completing this application and providing all required documents will help IMH determine if you qualify for discounted services or other public programs that can help you pay for your healthcare. Please complete the following form and submit to apply for free or discounted care **within 60 days following the date of discharge and receipt of outpatient care.**

To qualify, the services must be medically necessary.

The following are **not** considered medically necessary:

Cosmetic Services, Bariatric-related Services, Elective Services, Services not received at a IMH facility, Services deemed non-covered by Medicare, whether or not the patient is covered by Medicare.

Financial assistance is **not** typically available for:

Insurance copayments, Insurance deductibles, failure to comply with reasonable requirements such as obtaining authorizations or referrals and individuals who opt out of insurance coverage. ***You will still be asked to pay your insurance copay and deductible at the time of service. The availability of financial assistance is not a substitute for personal responsibility.***

To be considered for financial assistance you **must provide** the following:

- **A completed and signed Financial Assistance Application**
- **Medicaid denial letter**
- **Proof of Income** (Please provide each of the following or an explanation of why not provided)
  - Federal Income Tax (1040) return(s) for your household for the most recent calendar year. (If claiming spouse/dependents, they must be listed on the 1040)
  - Bank Statements of all bank accounts for the last 3 months.
  - Three (3) most recent pay stubs or a statement from your employer regarding your income.
    - If **self-employed,** please provide a copy of your last quarter's Business Financial Statement along with the previous year's Business Tax Return.
    - Unemployment statement showing denial or eligibility and amount receiving.
    - If **retired**, Social Security benefits and any pension.

- **Patient's indicating, they have no income must provide information as to how they are currently supporting themselves.**
- **Identification:**
  - One form of identification (i.e. driver's license, government issued photo I.D., social security card, birth certificate or passport)
- **Any other information that demonstrates financial hardship or need for financial assistance.** (i.e. public assistance award or denial letters, letters of support, etc.)

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security number is not required but will help the hospital determine whether you qualify for any public programs.

Financial Assistance Application

Patient Name_____ Date of Birth_____
Address_____
City_____ State_____ Zip Code _____
Home Phone _____ Cell Phone_____
Social Security # _____ Marital Status _____
Patient's Employer Name_____
Employment Length _____ Unemployment Date/Length _____

Spouse Name _____ Date of Birth _____
Spouse Employer Name _____
Employment Length _____ Unemployment Date/Length_____

Dependents (Must be listed on Federal Tax 1040 form)

1. _____ Date of Birth _____
2. _____ Date of Birth _____
3. _____ Date of Birth _____
4. _____ Date of Birth _____
5. _____ Date of Birth _____

Health Insurance_____ ID #_____
Secondary Insurance _____ ID #_____
Medicaid _____
Date of application _____ Date of Denial _____

Patient/Guarantor Certification

I,_____, CERTIFY the information I have provided is true and accurate to the best of my knowledge. I will apply for any state, federal, or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information may be verified by the hospital, and I authorize the hospital to contact third parties to verify accuracy of the information provided in this application, including running a credit bureau report. I understand that if I knowingly provide false information in this application, I will be ineligible for financial assistance, any assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Signature _____ Date_____

** For Office Use Only**