Union Health
P.O. Box 3054
Indianapolis, IN 46206
www.union.health

Financial Assistance Application

Plain Language Summary of Financial Assistance Policy

To meet the needs of the communities it serves and in recognition of its status as a nonprofit healthcare system, Union Health offers fair and equitable financial assistance for eligible patients who are unable to sustain the extraordinary burden of medical expenses due to limited income and resources.

The Union Health Financial Assistance Policy applies to emergency medical services and medically necessary health care services provided by Union Health. Services at some locations may be covered by a separate Sliding Fee Discount Program (visit **www.union.health** for details).

Generally, to be eligible for financial assistance, patients must have household incomes at or below 300% of the federal poverty guidelines and have no other resources for payment, such as health insurance, Medicaid eligibility or liability claims. To be eligible for full financial assistance, patients must have household incomes at or below 200% of the federal poverty guidelines and have no other resources for payment, such as health insurance, Medicaid eligibility, or liability claims. Financial assistance may also be available in other limited circumstances, depending on the amount of the patient's medical bills and whether the patient meets other criteria for eligibility.

Patients may apply for financial assistance by completing a Financial Assistance Application. Copies of the Financial Assistance Application, as well as Union Health's Financial Assistance Policy, are available at all patient registration sites or by visiting **www.union.health.** Patients may also request free copies of the Financial Assistance Application and the Financial Assistance Policy by calling the Union Health Public Benefits Department at (812) 238-7621 or writing Union Health, P.O. Box 3054, Indianapolis, IN 46206.

Persons seeking more information or needing assistance in completing the Financial Assistance Application may contact the Union Health Public Benefits Department at (812) 238-7621. A patient qualifying for financial assistance under Union Health's Financial Assistance Policy with respect to emergency or medically necessary healthcare services will not be charged more than the amounts generally billed by Union Health for the same services to patients who have insurance covering such care.

Translations of the Financial Assistance Policy, the Financial Assistance Application, and this plain language summary are available upon request.

Patient Information

Patient Name	Account Number

Street Address	City	State	Zip Code

Phone Number	Social Security Number

Household Information

PLEASE LIST ALL DEPENDENTS BY NAME & AGE; INCLUDING PARENTS, SPOUSE, AND BIOLOGICAL/LEGALLY ADOPTED CHILDREN UNDER 18 YEARS OF AGE

Name	Relationship	Age/DOB

Employment Information

Employer	Hours Per Week

Hourly Wage	Weekly Income	Monthly Income

Spouse Employer	Hours Per Week

Hourly Wage	Weekly Income	Monthly Income

Other Income

HOW ARE YOU BEING SUPPORTED?

For income listed above, you must provide the following for each member of the household:

☐ **Social Security:** $	☐ **Workers' Comp:** $
☐ **Disability:** $	☐ **CD'S:** $
☐ **Pension:** $	☐ **Stocks / Bonds:** $
☐ **Child Support:** $	☐ **Other:** $
☐ **Unemployment:** $	**Total: $**

Expenses

Rent / Mortgage	Utilities	Loan Payments

Charge Cards	Medical Expenses	Auto / Health Insurance

Food	Child Care	Other

I have applied for assistance through the following programs and was found to be ineligible:

☐ **Welfare / Medecaid:** Date	☐ **Disability:** Date

Authorization for release of information

MUST BE COMPLETED IN THE PRESENCE OF A HOSPITAL WITNESS FOR PURPOSES OF IDENTITY AND FINANCIAL LIABILITY

The above information is true and correct to the best of my knowledge. I understand the statements I have made on this form are subject to investigation and verification. I understand the statements I have made on this form are subject to made investigation and verification. I understand that I may be asked to provide proof of the information which I have given on this form, and I agree to help Union Health obtain the necessary verifications. I hereby authorize the release of wage information, financial information from banks and other financial institutions and from the Department of Health and Human Services to Union Health.

Patient Signature	Date

Spouse / Guarantor Signature	Date

Union Hospital Witness	Date