Lutheran Health Network
Charity Care/Financial Assistance Program Application

Patient Account Number: _____ Date of Application_____

PATIENT INFORMATION

Name_____

Address_____

City_____

State/Zip_____

Ph Number: _____

SS#_____

Employer_____

Address_____

City_____

State/Zip_____

Work Phone_____

Length of Employment_____

Supervisor_____

PARENT/GUARANTOR/SPOUSE

Name_____

Address_____

City_____

State/Zip_____

Ph. Number: _____

SS#_____

Employer_____

Address_____

City_____

State/Zip_____

Work Phone_____

Length of Employment_____

Supervisor_____

RESOURCES

Checking: yes___ no___
Savings: yes___ no___

Cash on hand: $_____

Vehicle 1: Yr_____ Make_____ Model_____
Vehicle 2: Yr_____ Make_____ Model_____
Vehicle 3: Yr_____ Make_____ Model_____

Charity Care/Financial Assistance Program Application cont

INCOME

Patient/Guarantor:
Wages(monthly): _____

Other Income: Child Support: $_____

VA Benefits: $_____

Workers' Comp: $_____

SSI: $_____

Other: $_____

Spouse/Second Parent:
Wages(monthly): _____

Other Income: Child Support: $_____

VA Benefits: $_____

Workers' Comp: $_____

SSI: $_____

Other: $_____

LIVING ARRANGEMENTS

Of Individuals in Household _____

Rent_____ Own_____ Other (explain) _____

Landlord/Mortgage Holder: _____

Phone Number_____ Monthly payment $_____

REQUIRED DOCUMENTS

The following documents must be attached to process your application for Charity Care/Financial Assistance:

Proof of Income: Prior year income tax return, last 2 pay check stubs, letter from employer, Social Security, etc. Last 2 months bank statements. Other documents as requested.

Proof of Expenses: Copies of medical bills reflecting patient liable amounts due or paid by the patient. Other documents as requested.

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me or failure to apply for or no cooperation in qualifying for other assistance will be cause for denial of assistance.

The Hospital reserves the right to pull a copy of your credit report.

Signature of Applicant_____

Hospital Representative Completing Application: _____

COMPLETED APPLICATION

Please submit the completed application by mail, fax or take into a Financial Counselor at the hospital.

Mail: Shared Services Center
Attn: Financial Counselor
1700 Magnavox Way, Suite 101
Fort Wayne, IN 46804

Fax: 260-443-0475
Attn: Financial Counselor