Decatur County Memorial Hospital
The Quality Care You Want. Close By.

PATIENT ACCOUNTS Financial Assistance Application Form

Applicant Name ____________________________ Birthdate ______________ SS#______________________

Street Address _______________________________ City _________________________ State ____ Zip______

Home Ph _________________ Cell Ph*___________________ Email* ________________________________
*by providing cell phone and/or email, I consent to communications through these methods for this application. This is also covered by the General Consent for treatment I have/will signed/sign, and by DCMH's HIPAA Privacy Policy at
https://www.dcmh.net/patients-visitors/patient-resources/

Do you have Health Insurance? Yes ________ No _________
Do you have Prescription Coverage? Yes ________ No _________
Have you applied for Medicaid Benefits? Yes ________ No _________

List all dependents/household members in the household below, except applicant (and on back or on separate sheet):

Name	Relationship	Birthdate	SS#

See back for additional program and documentation requirements.

Assistance for prescriptions is available to the **uninsured** person upon approval of this application. A twenty (20) day supply can be obtained at no charge while application is pending approval. See pharmacists. Restrictions may apply. DCMH Financial Assistance Program does not cover non-medically necessary cosmetic or elective services, or non-medical retail services, such as massage therapy, weight loss classes, cardiac rehab phase III services, etc.

All Decatur County Memorial Hospital employees are exempt from Pharmacy benefits thru the financial assistance program.

For application assistance or questions, call 812-663-1323 or email billing@dcmh.net

SIGNATURE: ____ Date:_________________

To Be Completed by Hospital Personnel

Monthly Income ____________ Monthly Expenses/Liability: ______________ Qualified Household Size: ___________
Annual Income ____________ Annual Expenses/Liability: ______________
Approved Program _____________ Reason for Denial ____
Reviewed By ____________________________ Approved By ____
Dates of Program Coverage (12 mos): Approval (From) Date: _________________ Through: ____________________

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Patients who may be eligible for certain third party assistance programs must cooperate with program requirements to maintain eligibility within the DCMH Financial Assistance Program.

Any three (3) of the following, indicating a Decatur County, Indiana address, are acceptable documentation for residency verification documentation:

1) Any document within the income verification listing with a preprinted address
2) Valid state-issued identification card
3) Recent (last 60 days) residential utility bill
4) Valid lease/rental/mortgage agreement
5) Current vehicle registration card
6) Voter registration card
7) Mail addressed to patient at a Decatur County, Indiana address from a Federal or State of Indiana government office
8) Award letter from school
9) Statement from a family member that the patient resides at the same address with one of the above residency verifications.

Income eligibility will be based on the most current published Federal Poverty Guidelines, and will use the prior year's Federal Tax Return showing all household members and their adjusted gross income, plus two (2) most recent pay stubs, and any of the of the following that apply to the current tax year not yet filed.
Proof of prior year and current year income may consist of Two (2) most recent pay stubs, W2 from all jobs held, Self-employment income and expenses, Unemployment compensation, or 1099 forms for the following types of income:

a) Social Security or Social Security Disability
b) Veteran's pension or Veteran's Disability
c) Private disability
d) Worker's compensation
e) Retirement Income
f) Child support, alimony or other spousal support
g) Other miscellaneous income sources.

In addition, please provide a summary of current household expenses and liabilities, such as monthly housing, transportation, food and medical expenses.

For applicants with Medicare coverage, or that did not file taxes, copies of statements for the following assets are required: patient's bank account balances such as checking and savings, money market accounts and certificates of deposit. A completed Financial Assistance application, dated and signed, is also required.

Applicants approved or denied for Financial Assistance may re-apply after six (6) months from the date of original application signature in the event there are substantial or unforeseen material changes in their financial situation. Applicants may appeal the application determination by sending a written appeal to the Executive Director, Revenue Cycle.