Dear Patient:

Attached you will find a Financial Assistance Application. You will need to complete this application as well as return the following documentation:

- Copy of 2017 Income Tax Return
- Copy of any child support received within the household
- Pay stubs for last 30 days
- Income for the household, Social Security, Pensions, Dividends, etc.

Patients may also be screen for Presumptive Eligibility through the Indiana Medicaid. This coverage which will help to pay for healthcare costs outside of DCMH. Additional application through Indiana Division of Family Resources may be required. You may contact them at 1-800-403-0864.

Household Size	**Yearly Income Limits**				
1	$ 23,340	$ 29,175	$ 35,010	$ 40,845	$ 46,680
2	$ 31,460	$ 39,325	$ 47,190	$ 55,055	$ 62,920
3	$ 39,580	$ 49,475	$ 59,370	$ 69,265	$ 79,160
4	$ 47,700	$ 59,625	$ 71,550	$ 83,475	$ 95,400
5	$ 55,820	$ 69,775	$ 83,730	$ 97,685	$ 111,640
6	$ 63,940	$ 79,925	$ 95,910	$ 111,895	$ 127,880
7	$ 72,060	$ 90,075	$ 108,090	$ 126,105	$ 144,120
8	$ 80,180	$100,225	$ 120,270	$ 140,315	$ 160,360
Approved Pricing	Hospital/Dr.'s Visits 100% Prescriptions = Pharmacy cost plus 10%	Hospital/Dr.'s Visits and Retail Pharmacy 90% Off	Hospital/Dr.'s Visits and Retail Pharmacy 70% Off	Hospital/Dr.'s Visits and Retail Pharmacy 50% Off	Hospital/Dr.'s Visits and Retail Pharmacy 30% Off

Assistance for prescriptions is available to the uninsured person upon approval of this application. A (20) day supply can be obtained at no charge while application is pending approval. See our Pharmacists. Restrictions may apply. All Decatur County Memorial Hospital Employees are exempt from Pharmacy benefits thru the financial assistance program. Need help completing the application, please contact the Patient Accounts Department at (812)663-1323.

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

DATE: _____

FINANCIAL ASSISTANCE APPLICATION

Patient Name _____ Date of Birth _____SS#_____

Street Address _____ City _____ State _____ Zip_____

Home Phone _____ Cell Phone _____

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 in the household:

Name	Relationship	Date of Birth	SS#	Monthly Income

Total Monthly Income _____

If no income, how are you meeting your monthly living expenses? _____

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.

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

SIGNATURE: _____

Required Documentation:

Income Tax Return for previous year _____
Income Verification:

Pay Stubs:		SSI Income:	SSI or Checking Account Statement
Child Support:	Print out from Child Support	Unemployment:	Print out from Unemployment

To Be Completed by Hospital Personnel

Monthly Income _____ Yearly Income _____ Qualified Family Size _____
Approved Program _____ Denied Reason for Denial _____
Reviewed By _____ Approved By _____
Dates of Program Coverage (6mos) From _____ Through _____