Financial Assistance Policy (FAP) Application

marionhealth.com • Business Office (765) 660-6100 • Physicians' Billing (765) 660-7600

PATIENT AND FAMILY INFORMATION

Patient Name _____ SSN ___-___-___ Birth Date ___/___/___

Spouse/Guarantor Name _____ SSN ___-___-___ Birth Date ___/___/___

Address _____ City _____ State _____ Zip _____

Phone _____

Number of Dependents _____

	DEPENDENT NAME	RELATIONSHIP	SSN	BIRTH DATE
1.			- -	/ /
2.			- -	/ /
3.			- -	/ /
4.			- -	/ /
5.			- -	/ /

Note: Number of dependents in household includes patient and the following individuals who live with the patient: patient's spouse, patient's biological, adoptive or step children under the age of 18.

A. EMPLOYMENT INFORMATION

GROSS MONTHLY INCOME BEFORE TAXES $ _____

Note: Documentation is required to support income submitted. Last year's income tax return or W-2 forms, verification of Social Security and/or pension benefits, 3 most recent pay stubs if there has been a change in income from last year or other proof of annual income.

B. POTENTIAL SOURCES OF INCOME *(Please list all potential sources of income)*

a. Federal Taxable Wages (from your job) $ _____

b. Tips $ _____

c. Self-Employment Income $ _____

d. Unemployment Compensation $ _____

e. Social Security $ _____

f. Social Security Disability Income (SSDI) $ _____

g. Retirement or Pension Income $ _____

h. Capital Gains $ _____

i. Investment Income $ _____

j. Rental and Royalty Income $ _____

k. Excluded (untaxed) Foreign Income $ _____

l. Checking $ _____ Savings $ _____ CD $ _____

m. Estimated Home Value $ _____

VERIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

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 I will be asked to provide proof of the information which I have given on this form, and I agree to help the hospital 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 Marion Health.

Patient's Signature _____ Date _____

Spouse/Guarantor's Signature _____ Date _____

Please do not hesitate to contact us if you have any questions. This application is good for 6 months at which time a new application should be submitted.