UAP/UHMG Financial Assistance Application
221 South 6th Street
Terre Haute, In 47807
812-242-3155/812-238-7783

A. **Family Information**:
Patient Name: _____Account#_____

Patient Address: _____Phone#_____

_____Pt. SS#_____

Dependents by Name & Age: _____

_____

Guarantor Name: _____

B. Employment Information:
Guarantor Employer: _____Hours per week:_____
Hourly Wage: _____ Weekly Income: _____**Monthly Income**: _____
Spouse Employer: _____ Hours per week: _____
Hourly Wage:_____ Weekly Income:_____**Monthly Income**:_____

C. Other Income:
Social Security: _____ Disability: _____Other Income: _____
Child Support: _____Unemployment:_____Pension:_____
Workers Comp: _____CD's_____Stocks/Bonds: _____

TOTAL INCOME: _____

I have applied for assistance through the following programs and was found to be ineligible for assistance:
HCI: _____Welfare/Medicaid: _____Trustees:_____ Disability: _____

Please state the reason you are requesting financial assistance: _____
_____
_____

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 that I may be asked to provide proof of the information which I have given on this form, and I agree to help UAP/UHMG 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 Hospital.

Patient Signature: _____

Spouse/Guarantor Signature: _____

UAP/UHMG Witness: _____Date:_____

UAP Clinic, LLC/Union Hospital Medical Group

Dear Patient,

Please find enclosed an application for help with your bill and your current statement. You will need to fill out the application in full and sign, date and return it to our office in the postage paid envelope provided. **We require proof of income in order to complete the review of your application.** Please include the income applicable to your household such as child support, pension, unemployment, disability, worker's compensation, and any other additional sources of income. Please submit copies of the information requested, originals will not be returned.

List of items to submit with your application, submit those that apply to your situation:

- Copies of pay stubs (unemployment benefits, food stamps, tanif, retirement, etc.) for the last 30 days for you and your spouse (if married) or last years 1040 (if you claim dependents), whichever reflects the most current income (if self-employed, please provide bank statements reflecting deposits only) *If no current income a wage inquiry from your local unemployment office will suffice.

- Copies of award letter from social security/disability for you and your spouse (if married) or bank statement showing direct deposit (you may white-out any information not pertaining to your income).

- Copies of proof of any pension/retirement income.

- Child support paid to you.

- Letter from family or friends documenting the financial support they are giving you. If you are receiving help or support from anyone other than a spouse, explain what means of support. We need something in writing that shows how you are making ends meet.

- Proof of indigent care.

- Medicaid Denial letter. You may contact our Claimaid representative, Kelly Enright, at 812-242-3475 to complete a Medicaid application.

Sincerely,

UAP/UHMG Patient Accounts

812-242-3479/812-238-7783