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

PATIENT ACCOUNTS Financial Assistance Application Form

Applicant Name _____ Birthdate _____

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

See page two 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

Submit completed application via email to billing@dcmh.net or at Billing/Patient Accounts located in the main hospital.

APPLICANT SIGNATURE: _____ Date:_____

----------**To Be Completed by Hospital Personnel**----------

Applicant SS#_____ Dependent/household SS#_____
Monthly Income _____ Monthly Expenses/Liability: _____ Qualified Household Size: _____
Annual Income _____ Annual Expenses/Liability: _____
Approved Program _____ Reason for Denial _____
Reviewed By _____ Approved By _____

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Dates of Program Coverage (12 mos): Approval (From) Date: _____ Through: _____

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 one (1) 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 lease/rental/mortgage agreement
3) Current vehicle registration card
4) Voter registration card
5) Mail addressed to patient at a Decatur County, Indiana address from a Federal or State of Indiana government office
6) Award letter from school
7) 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 Ret photo 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 one month 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.

Also required:
3 months bank statements, checking and savings, money market accounts and certificates of deposit.
The prior year's tax returns
Valid state-issued photo identification card
Recent (last 60 days) residential utility bill
Same documentation will be requested from the dependents living at the home.

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.