219 Health NETWORK

Guarantor Name	Guarantor Social security number	Guarantor date of Birth	Guarantor number
Patients Name(S)	Guarantor Phone Number	Patient Account Number(s)	

You may be eligible for our SLIDING FEE PROGRAM if you are unable to pay your bill in full. Please fill out the below form and send in the required information in the next 10 days. We will evaluate your financial need to see if you qualify for partial or full assistance. You must provide information for BOTH the patient/guarantor and spouse if applicable.

Name of Person Applying for Assistance: _____
Number of Family Members claimed on tax return: _____

Monthly Income:

SALARY/WAGES:
Patient: $_____
Spouse: $_____
SOCIAL SECURITY: $_____
PENSION INCOME: $_____
RENTAL INCOME: $_____
DISABILITY INCOME $_____
UNEMPLOYMENT INCOME: $_____
TOTAL INCOME: $_____

Please send copies of the items below:
Note: Application cannot be processed without the following if applicable:

- Most recent federal tax return with supporting schedules and W-2. Return must be signed.
- Current pay stubs for the last 30 days.
- Most recent bank statements for all bank accounts. Include all pages
- If self-employed, most recent quarterly business profit/loss statement.
- Proof of non-wage income (i.e unemployment, child support, alimony, trust, pension, interest)
- If not employed, a letter showing means of support signed by person supporting you.
- Award Letter for Food Stamps
- If you applied for government or state assistance, provide proof of approval or denial.
- Proof of separation

I CERTIFY THAT:

- ☐ The information stated in the application is an accurate and complete statement of my financial status.
- ☐ I have declared all sources of income as requested.
- ☐ I authorize 219 Health Network to check credit history, employment status and make all inquiries deemed necessary to complete this application process for financial assistance.
- ☐ I understand that untrue or incomplete information is cause for denial

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I agree that it is my responsibility to notify 219 Health Network of any changes in annual income, family size and other circumstances. I also understand that if I/we do not agree with any decision regarding this application, we have the right to request the application and the decision be reviewed by 219 Health Networks Executive Director or his/her designee.

_____
Patient Name (Printed)

_____
Patient Signature

_____
Date Signed

Please return information within 10 days.
Via Fax: 219-703-6749
Or Mail to: 219 Health Network Inc. / Patients Accounts
100 West Chicago Ave Suite F
East Chicago, IN 46312