Financial Assistance Policy
Plain Language Summary

Hendricks Regional Health (HRH) Financial Assistance Policy (FAP) exists to provide eligible patients, partially or fully – discounted emergent or medically necessary care. Patients who seek Financial Assistance must apply for the program, which is summarized below.

Eligibility – Residents of Hendricks County and surrounding primary service areas are eligible to apply. Emergent or medically necessary healthcare services provided by Hendricks Regional Health, both hospital and physician practices may be covered under FAP. Other services such as pathology, ER physicians and radiology are examples of services that may not be eligible under the HRH Financial Assistance Policy. It is the patient's responsibility to contact each service provider to inquire about participation with Hendricks Regional Health's FAP.

FAP Requests and Application Process

- First, obtain a free financial assistance application and copy of the FAP by contacting us in a method described below. You may also seek help with completing an application by contacting us
  - **In person:**
    - Patient Financial Services 252 Meadow Dr. Danville, IN 46122
    - Admitting area or Emergency department-Hendricks Regional Health hospital locations in Danville and Brownsburg
  - **By phone** at 317.745.3534
  - **Online** at www.hendricks.org/financialassistance
- Submit (via mail or in person) completed applications and supporting documentation, as outlined in the application instructions, to:

  Hendricks Regional Health
  Patient Financial Services
  252 Meadow Drive
  Danville, IN 46122
- Application Period – A completed application packet (application and all required documents) will be accepted for 240 days from the date of the first post discharge statement of eligible services
- Incomplete applications cannot be processed. Accounts will be pended, and applicants will be notified in writing and given 30 days from the date of the notification to submit the required documentation.

Determination of Financial Assistance Eligibility – Hendricks Regional Health uses the Federal Government's Federal Poverty Guidelines (FPG) as a base for our FAP eligibility determination. Eligible persons will have their care fully or partially covered and will not be billed more than Amounts Generally Billed (AGB) to insured persons as defined by IRS Section 501(r).

Household Size	Household Income	Household Size	Household Income
1	**$58,320**	**5**	**$140,560**
2	**$78,880**	**6**	**$161,120**
3	**$99,440**	**7**	**$181,680**
4	**$120,000**	**8**	**$202,240**

Questions: Please call us at 317.745.3534, M-F 8:30-4:30

Financial Assistance Application

Name: _____

Account Number: _____

Important: You may be able to receive free or discounted care.
Completing this application will help Hendricks Regional Health determine if you are eligible for free or discounted services under its Financial Assistance Program.

Please complete this form as soon as possible after the date of service in order for Hendricks Regional Health to determine your eligibility for financial assistance. We will accept your application for up to 240 days following the date of the first post-discharge patient statement.

Guarantor Information				
Name	Date of Birth	Preferred Phone Number		
Home Address	City	State	Zip Code	County of Residence
Applicant's Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐Widow				
Social Security Number	Health Insurance Information	Employer:		
		Monthly Gross Income:		
Employment Status ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐Unemployed				

Please list everyone in your household below - include yourself and all individuals eligible to be listed on your federal tax return. For families larger than five members, please attach a list of additional household members.

Full Legal Name	Date of Birth	Social Security Number	Relationship	Employer

Questionnaire	
Did you have health insurance on the date(s) services were provided?	☐ Yes ☐ No
Have you applied for Medicaid or other state or federal assistance? If yes, please specify program: Date applied:	☐ Yes ☐ No
Were the services provided related to any of the following? ☐ Yes ☐ No If yes, ☐ Accident ☐ Crime ☐ Workplace Injury ☐ Other:	If yes, date of injury
Do you have a Health Savings Account (HSA)? If yes, what is the current balance?	☐ Yes ☐ No
Do you participate in a Cost-Sharing or Medi-Share Program? If yes, please list the amount of payment received:	☐ Yes ☐ No

Financial Assistance Application

Name: _____

Account Number: _____

Presumptive Eligibility

Uninsured patients or guarantors who ***provide proof of eligibility*** for one of the programs listed below, individually or through the benefits provided to their family, may be automatically eligible to receive assistance.

Check as many as apply and provide supporting documentation:

☐ TANF	☐ SNAP
☐ WIC	☐ Indiana Free or Reduced Lunch Program
☐ Indiana Children's Special Health Care Services	☐ Low Income Home Energy Assistance Program
☐ State Medicaid Programs (Patient with Coverage Only)	☐ Homeless
☐ Patient Deceased with No Estate	☐ Unlisted State or Federal Income Based Program:

If you qualify for financial assistance based on eligibility for one of the programs above, **STOP** – you are done. Please sign the Applicant Certification on the bottom of this page and submit your application with ***proof of eligibility*** for the applicable program(s). Unlisted programs may require additional documentation.

Required Information and Supporting Documentation

Valid Government-Issued Photo ID:

- ☐ Driver's license, passport, etc.

Tax Documents (Submit all that apply):

- ☐ Most recent State and Federal Income Tax forms including Schedules C, D, E and F if filed

Proof of Income for all Household Members (Submit all that apply):

- ☐ Most recent two months of employer/unemployment stubs
- ☐ Self-Employment Worksheet (available online at hendricks.org/FinancialAssistance)
- ☐ Current Year Social Security Benefit Letter (if applicable)
- ☐ Supporting documentation for all additional sources of income (e.g., IRAs, annuities, etc.)
- ☐ WorkOne Authorization form (if currently unemployed)

Proof of Assets:

- ☐ Two most recent statements from all of your checking and savings account(s)

If an applicant does not have any of the listed documents to prove income, he or she may call the Patient Accounts department to discuss other evidence that may be provided to demonstrate eligibility.

Application Certification:

I certify that the information in this application is true and correct to the best of my knowledge. I understand that the information provided may be verified by Hendricks Regional Health and I authorize Hendricks Regional Health to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information or withhold relevant information, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed and I will be responsible for the balance.

_____ _____

Guarantor Signature Date

Submit completed applications:

In person or by mail
Hendricks Regional Health
Attn: Financial Counselor
252 Meadow Drive
Danville, IN 46122

Need Assistance?

If you have questions about or need assistance to complete this application process, please contact the Patient Accounts department at 317.745.3534
8:30 a.m. to 4:30 p.m. Monday through Friday.

INDIANA
DEPARTMENT OF
WORKFORCE
DEVELOPMENT

RELEASE OF INFORMATION

***APPLICANT'S NAME:** _____

Additional names used during employment: _____

***SOCIAL SECURITY or INDIVIDUAL TAX IDENTIFICATIONNUMBER ---------- _____**

****Applicant contact information***

Email Address:_____ **Phone Number:**_____-_____-_____

Street Address: _____

City:_____ **State:**_____ **Zip:** _____

I authorize the Indiana Department of Workforce Development to release all wage and unemployment benefit information to the organization below.

_____ _____

***SIGNATURE OF APPLICANT** ***TODAY'S DATE:**

NOTE: RELEASE MUST BE SUBMITTED WITHIN 90 DAYS OF APPLICANT SIGNING RELEASE FORM.

☐ **Check this box if a Power of Attorney is attached.**

NOTE: This section must be completed by the organization requesting employment history.

By signing below you agree that you understand that data we release to you is protected under state law (IC 22-4-19-6) and federal regulations (20 CFR § 603.5) as confidential information. You also confirm that you have verified the applicant's identity by viewing some type of photo identification.

***SIGNATURE OF REQUESTOR:** _____

***Printed Name of the Requestor:** _____

*** Requesting Organization:** Hendricks Regional Health

***Email Address:** _____

***Phone Number:** 317-718-_____ **Fax Number:** 317-745-8400

****REQUIRED FIELDS***

*****Applicant's phone number, email address, or mailing address is required.***

Email employverification@dwd.in.gov to reach a DWD employment history or LKE website specialist.

LKE Form

Hendricks Regional Health

1000 East Main Street
P.O. Box 409
Danville, IN 46122-0409
Phone: (317) 745-3534
Fax: (317) 745-8400
www.hendricks.org

2023 SELF-EMPLOYMENT FOR FINANCIAL ASSISTANCE

BUSINESS NAME: _____

I,_____am self-employed and estimate, after all expenses, my income for 2023 to be:

$_____.

Signature: _____

Date: _____