



Account Number(s) \_\_\_\_\_

Account Number(s) \_\_\_\_\_

Patient Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

SS#: \_\_\_\_\_

Birthdate: \_\_\_\_\_

If any immediate family members also have accounts with Goshen General Hospital that you would like considered for Financial Assistance, please list their names and account numbers below:


Employer: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Spouse: \_\_\_\_\_

Spouse SS#: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_

**If patient** Father: \_\_\_\_\_

Mother: \_\_\_\_\_

**is a minor:** Father SS#: \_\_\_\_\_

Mother SS#: \_\_\_\_\_

Father's Employer: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_

**Insurance Information**

Do you have insurance to pay your hospital bill? Yes/No

Is insurance accessible to you through your employer? Yes/No

Have you applied for Medicaid? Yes/No

Approved? Yes/No Medicaid Number: \_\_\_\_\_

	<u>Cash on Hand</u>	<u>Banking Institution</u>
Checking	\$ _____	Location: _____
Savings	\$ _____	Location: _____
CD's	\$ _____	Location: _____
Mutual Fund	\$ _____	Location: _____
<b>Total</b>	\$ _____	

**Monthly Totals**

Total Monthly Income: \$ \_\_\_\_\_

Other Income: \$ \_\_\_\_\_

Food Stamps: \$ \_\_\_\_\_

S.S.I.: \$ \_\_\_\_\_

Retirement: \$ \_\_\_\_\_

Child Support \$ \_\_\_\_\_

Unemployment: \$ \_\_\_\_\_

TANF from the State \$ \_\_\_\_\_

**Total Net**

**Household Income** \$ \_\_\_\_\_

Total Number of persons in patient's **immediate family** living in the household:

	<u>Expenses</u>	<u>Monthly Payment</u>	<u>Balance Owed</u>
	House Payment/Rent	\$ _____	\$ _____
	House Insurance	\$ _____	\$ _____
	Property taxes	\$ _____	\$ _____
	Primary Car Payment	\$ _____	\$ _____
	Primary Car Insurance	\$ _____	\$ _____
	Medical/Pharmacy	\$ _____	\$ _____
	Child Support	\$ _____	\$ _____

**Assets**

Do you own your home? Yes/No If yes, please list current value:

Do you have a current mortgage on your home? Yes/No If yes, please list current balance:

Do you own any other property? Yes/No If yes, please list current value:

(ex: vehicle, boat, motorcycle, additional property) Item: Value:

Item: Value:

By my signature below, I state that the information given in this application is true and accurate to the best of my knowledge.

I also authorize Goshen General Hospital to verify my credit and employment history and my financial accounts.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



GOSHEN HEALTH SYSTEM  
**GOSHEN GENERAL HOSPITAL**

***Additional Documentation Required***

Please send copies of documentation for the following items. This documentation is necessary to complete your application for assistance. All documentation must be current. Please be aware that you must have exhausted all other forms of assistance and be unable to establish a payment plan to qualify for financial assistance.

1. All forms of income-The last 2 paystubs if paid bi-weekly or the last 4 if paid weekly. Please include spouse's income\*\*, child support, unemployment benefits, social security benefits, and/or any other form of income.
2. Current bank statement(s)-checking and savings

**\*Upon review of your application, additional documentation may be requested. Your application will not be processed if you do not send all required documentation.\***

\*\*Separated Couples-If you cannot provide written proof of legal separation, you must include all required documentation for your spouse.

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***Your application and all documentation are due back no later than: \_\_\_\_\_***  
**Please mail completed application along with the required documentation to:**

**Goshen General Hospital  
Attn: Financial Advocate  
200 High Park Avenue  
Goshen, IN 46526**

**If you have questions, please feel free to contact our Financial Advocate at (574) 535-2607  
Hours: Monday -Friday 7:00 - 5:30**

**Upon receipt of your completed application, it will be processed and a  
Financial Advocate will contact you within 2 weeks.**