COMMUNITY HEALTHCARE SYSTEM®

| Guarantor Name | Guarantor Social Security Number | Guarantor Date of Birth | Guarantor Number |
|---|---|---|---|
| | | | |

| Patient Name(s) | Guarantor Phone Number | Patient Account Number(s) |
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You may be eligible for our HELPING HAND PROGRAM if you are unable to pay your bill in full. Please fill out the form below 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: $ _____
**RENTAL INCOME:** $ _____
**DISABILITY INCOME:** $ _____
**SOCIAL SECURITY INCOME:** $ _____
**UNEMPLOYMENT INCOME:** $ _____
**TOTAL INCOME:** $ _____

**ASSETS:**

**CASH ON HAND:** $ _____
**BANK ACCOUNTS:** $ _____
Savings: $ _____
Checking: $ _____
Trust: $ _____
Credit Union $ _____

**INCOME PRODUCING REAL ESTATE:** $ _____
**STOCKS/BONDS:** $ _____
**OTHER:** $ _____
**TOTAL ASSETS:** $ _____

**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 statement for all bank accounts. Include all pages.
- Proof of assets listed above.
- 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.

**Community Healthcare System may use all or a portion of the above documents to approve charity care eligibility.**

I CERTIFY THAT:

- The information stated in the application is an accurate and complete statement of my financial status.
- I have declared all assets and sources of income as requested.
- I authorize Community Healthcare System 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.

Signature of Patient/Responsible Party:_____ Date: _____

**Please return information within 10 days.**
**Via Fax: 219-934-8986**
**Or Mail: Patient Accounts Helping Hand Program Application**
**PO Box 3604**
**Munster, IN 46321-0703**
**Online: Go to comhs.org and click on Contact to upload documents**