River Bend Hospital Financial Assistance Application

Patient Information

Name (Last, First, Middle Initial)	Birth Date (mm/dd/yyyy)	Social Security Number	
Address	City	State	ZIP Code

Phone Number	Email Address (optional)	Marital Status □ Single □ Married □ Divorced □ Separated □ Widow

Employment Status □ Employed □ Self-Employed □ Unemployed □ Retired □ Disabled □ Student	Employer Name	Employer Phone Number
Length of Current Employment	Present Salary: (week/month/year)	Child Support/Alimony Received ($weekly/monthly)
Other monthly Income: (monthly)		

Household Dependents

Adults and/or minor dependents included on your Federal tax return that you provide more than 50% support.

Full Name	**Relationship**
1.	
2.	
3.	
4.	

Insurance

Do you currently have insurance coverage? (Persons under the age of 26 may be covered by their parent's insurance)
□ No □ Yes ____

Have you applied for Indiana Medicaid in the last 12 months? □ Yes □ No

If yes, what was the outcome? □ Approved □ Denied □ Pending □ Not Eligible

VII: Signature and Date Required

I certify that all information listed is accurate to the best of my knowledge. I understand that fraudulent or misleading information will make me ineligible for financial assistance. I permit River Bend Hospital and affiliated entities to verify the information provided on this application, including verifying employment and financial information.

Patient Signature	**Sign Date (mm/dd/yyyy)**

Additional Information:

Approved for Financial Assistance	**Sign Date (mm/dd/yyyy)**
Account number:	

Updated 2.2023