Hancock Health Financial Assistance Application

Plain Language Summary

Thank you for choosing Hancock Health for your healthcare needs. We offer financial assistance to patients who are uninsured, underinsured, or facing financial hardship in covering out-of-pocket expenses for services provided by Hancock Regional Hospital, Hancock Physician Network and Hancock Gateway.

Application Process

Applications may be obtained by calling Patient Financial Services at 317-468-4687, in person at any Hancock location, online at https://www.hancockhealth.org/patient-hub/.

Applications must be fully completed and submitted with required documentation as noted on page 1 of the application.

Additional information may be requested after submission, with a 15-day deadline to provide the necessary details.

A valid signature is required. If a power of attorney or guardian of a minor completes the form, they must sign and specify their relationship to the patient.

Applications must be submitted within 240 days of the post-discharge patient statement.

Applications will be processed within 30 days of receipt of the completed form and required documentation.

Applicants will receive a letter by mail regarding the outcome.

Eligibility Criteria

Financial assistance applies only to emergency or medically necessary services. Medically Necessary Services are services provided to diagnose, alleviate, correct, cure, or prevent conditions that threaten life, cause suffering, result in deformity or malfunction, or lead to illness or disability.

Hancock Health requires all third-party reimbursement options to exhausted before approving charity care.

Applicants may be required to apply for external assistance programs such as Medicaid, HIP, or public marketplace insurance before receiving financial assistance. Our Financial Counselors are available to help with this process.

Applications are evaluated based on gross household income (before taxes and other deductions) and household size as reported on tax returns. Proof of income, including non-work-related sources, is required.

If no income is reported, applicants must explain how essential needs such as food, shelter, and clothing are met.

Financial assistance may be granted based on special circumstances demonstrating hardships beyond standard criteria.

Hancock Health may perform a soft credit inquiry to help verify your financial status and determine eligibility.

Financial Assistance Levels

Patients with household income below 150% of the Federal Poverty Level (FPL) may receive free care. Patients with income between 150% and 300% of FPL may be eligible for discounted care.

Hancock Regional Hospital ensures that no patient eligible for financial assistance is charged more than the Amounts Generally Billed (AGB), as required by IRS Section 501(r). Hancock Physician Network and Hancock Gateway apply a sliding scale.

Hancock Regional Hospital reviews the calculated AGB on an annual basis using a twelve (12) month lookback period is used. Includes Medicare Fee for Service and Commercial payers.

Patients with household income above 300% of the FPL may receive partial assistance if the balance exceeds 10% of annual household gross income.

Special circumstances such as employment status, assets, future earning capacity, and other financial resources may be considered as exceptions to eligibility.

Discounts for uninsured patients will be applied to gross charges or to remaining balance after SP discount applied.

Payment Obligations

Any remaining balance after assistance must be resolved within 60 days. If you are unable to resolve the balance within 60 days, please contact our Billing Office at 317-907-1234 to arrange an alternative payment plan.

Approved applications remain valid for 180 days of the application date. If household income changes within that timeframe, you may need to notify our office.

Non-payment of remaining balances after assistance and applicable discounts may result in collection proceedings, including the reversal of discounts.

If an account is with a collection agency, financial assistance may still be granted, but previously paid amounts will not be refunded.

Important Considerations

Hancock Health does not consider race, gender, age, sexual orientation, religious affiliation, or immigration status in determining eligibility.

Our financial assistance program does not apply to the Hancock Surgery Center.

Contact Information

If you have questions or need assistance, please call 317-468-4687, email us PFS@HancockRegional.org or visit us in person at the hospital. Completed applications should be submitted to:

Hancock Health
Attn: Financial Counselor
801 N State Street
Greenfield, IN 46140

Hancock Health

Financial Assistance Application

		Primary Applicant MRN:	
Applicant's Name First	**MI**	**Last**	**Date of Birth**
Address			**Primary Phone**
City	**ST**	**Zip**	**Work Phone**

List ALL household Members: this includes all individuals listed on your federal tax return. Please attach an additional list is there are more than 8 family members.

Name	Date of Birth	SSN	Relationship to Applicant
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Monthly Income		Monthly Expenses	
Responsible Party's Gross Income (before taxes)	$	Rent or Mortgage	$
Other Household Gross Income (before taxes)	$	Utilities/Phone/Internet	$
Investment Income (Annuities/Stocks/Dividends)	$	Household Vehicles (Year/Make/Model)	$
Child Support/Alimony Received	$	1.	$
Rental Property Income	$	2.	$
Pension/Retirement/Unemployment/Social Security	$	Health Insurance Costs	$
Food Stamps	$	Other Medical Bills/Pharmacy Expenses	$
Other:	$	Other:	$
Total Monthly Income (before taxes)	$	**Total Monthly Expenses**	$
Assets		**Liabilities**	
Checking Account Balance	$	Residence Loan Balance/Mortgage	$
Savings Account Balance	$	Balance Owed on Credit Cards	$
Value of Vehicle 1	$	Auto Loan Balance	$
Value of Vehicle 2	$	Total Medical Bills	$
Other:	$	Real Estate Tax	$
Total Value of Assets	$	**Total Liabilities**	$

Did you have insurance coverage on the date(s) Services were provided? Yes / No

If yes, please list Insurance Company:

Have you applied for Medicaid or other state or federal assistance? Yes / No

If yes, please specify which program: Date Applied: Approved? Yes / No

Have you applied for public assistance Yes / No

If yes, please check all that apply TANF SNAP WIC

Other:

Required Documentation

- [ ] Drivers License or other government issued ID
- [ ] Proof of income, including pay stubs or employer statement documenting wages for prior three (3) months, pension documents
- [ ] Prior year's income tax return including W-2's
- [ ] Two (2) most recent detailed bank statements, including checking, savings and any other investments

Additional Information, if applicable

- [ ] Copy of Social Security Letter / SSDI
- [ ] Public Assistance approval or denial letter
- [ ] Unemployment compensation form / application form
- [ ] Copy of any other medical bills, current date
- [ ] Court Documents

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at the time of registration or indicated above. I understand that providing false information will result in denial of the application for any type of financial assistance through Hancock Health. If I am entitled to any action against or settlement from third-party payers, I will take any action necessary or requested by Hancock Health to obtain such assistance and will assign to Hancock Health, and upon receipt will pay to Hancock Health, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by Hancock Health will result in the denial of this application. I also authorize Hancock Health to check my credit history through the credit bureau, if deemed appropriate.

I also authorize Release of Information from the Division of Family Resources to Hancock Health Patient Financial Services regarding application approval/denial for Food Stamps and/or Hoosier Healthwise/Medicaid.

I acknowledge that I am financially responsible for any remaining balance following the determination of my financial assistance status and application of any requisite discounts. Balance must be paid within 60 days of determination. If unable to pay in full within 60 days, alternat payment plan arrangements must be made.

Signature	Date

For Office Use Only

Accepted For Processing By	Date Received

Additional household members for which the application is intended	MRN(s)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	