INcompass Healthcare

Exceptional care for everyone

Client ID: _____

Please return to:

INcompass Healthcare
ATTN: Patient Accounts
285 Bielby Road
Lawrenceburg, IN 47025
Or by email
financialservices@incompasshc.org

Financial Assistance Application

Please complete this form accurately and in full. This information should include anyone you can claim on your taxes.

Client Information	
Name:	Email:
DOB:	Marital Status*:
SSN*:	Employer Name:
Phone #:	Employer Phone #:
Address:	
Guarantor Information (if different than client)	
Name:	Email:
DOB:	Marital Status*:
SSN*:	Employer Name:
Phone #:	Employer Phone #:
Address:	
Spouse Information	
Name:	Email:
DOB:	Marital Status*:
SSN*:	Employer Name:
Phone #:	Employer Phone #:
Address:	
Dependents	
Name:	DOB:
Name:	DOB:
Name:	DOB:
Name:	DOB:
Total # of Household Members:	

* -- Marital Status and SSN optional

Please provide your yearly household income information below. This is based on income earned in the past year, not your current or future income.

Income Sources	Client	Other	Total
Gross wages, salaries, tips, etc. before any deductions.			
Income from business and self-employment			
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income			
Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources			
Total Yearly Household Income			

Please provide supporting documentation for any income listed above. **This is required for your application to be processed.** Examples include:

- Four of your most current pay stubs from employer
- W-2 earnings statement/tax return
- Social security statement of earnings or Supplemental security income -SSI
- Unemployment compensation determination letters
- Worker's compensation
- Retirement benefits/pension
- Veterans' benefit statement
- Statement of self-employment earnings

Any discount awarded will be valid for 1 calendar year and will apply to all services received at INcompass Healthcare during this time. You are required to inform INcompass Healthcare if there are any changes to any of the information provided.

I certify that all the information provided on this application is accurate.

Responsible Party Name

_____

Responsible Party Signature **Date**

_____ _____

Office Use Only

Client Name: _____ Client Account #_____

# of Household: _____

Yearly Household Income: _____

Approved: ☐ Denied: ☐ Denial Reason: _____

Approved Discount: _____

Approved By: _____

Date Approved: _____

Expiration Date: _____