INcompass Healthcare

Exceptional care for everyone

Client ID: _____

Return in person at any INcompass location
Mail To:
INcompass Healthcare
ATTN: Client Financial Services
285 Bielby Road
Lawrenceburg, IN 47025
Email To:
financialservices@incompasshc.org

Financial Assistance Application

Please complete this form accurately and completely. 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 (supporting documentation required below)	
Name:	DOB:
Name:	DOB:
Name:	DOB:
Name:	DOB:
Total # of Household Members:	

* -- Marital Status and SSN optional

Revised 7/2/2026

Please provide your estimated annual household income. Estimate your annual income based on the income earned during the past 3 months. If you are married, include your spouse's income.

Income Sources	Client	Other	Total
Gross wages, salaries, tips, etc. before any deductions.			
Income from other 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

If you currently do not earn any income from any source, you must complete and submit a **No Income Attestation Form** along with this application. If your income changes at any time while your Financial Assistance Application is active, you are responsible for notifying us and providing updated income information.

Any discount awarded will be valid for 12 months from the date of approval 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 to the best of my knowledge. I understand that providing false or misleading information may affect my eligibility.

_____

Responsible Party Name

_____ _____

Responsible Party Signature **Date**

Office Use Only

Client Name: _____ Client Account #_____

# of Household: _____

Yearly Household Income: _____

Medicaid Application Determination: _____

FAA Determination:

Approved: ☐ Denied: ☐ Reason: _____

Approved Discount: _____

Approved By: _____

Date Approved: _____

Expiration Date: _____