

Patient Eligibility Application

Do you have Medicare?	Yes	No	Do you have Medicaid?	Yes	No
Do you have medical insurance?	Yes	No	Do you have Healthy Indiana Plan?	Yes	No
Are you a Veteran?	Yes	No	Can you use the Veteran's Clinic?	Yes	No

If you need assistance, please contact us at 812-333-4001 (ext. 117) or 812-333-4039 Office Use: New or Recert

Copies of the following documents are required with application:

1. **A complete copy of your last Federal Income Tax papers, including:**
 - a. **Form 1040, pages 1&2 or Form 1040EZ**
 - b. **All W-2's and/or 1099's**
 - c. **Schedules if filed**

If you cannot locate a copy of your Federal Tax return, you may obtain a transcript from the IRS office at 2017 S. Liberty Drive, Bloomington, IN 47403

2. **Payroll check stubs or verification of income for everyone in the household from list below:**
 - a. **If unemployed and not receiving any income, a KWE356S is required from the the WorkOne/unemployment office.**
 - b. **Social Security, SSI, SSDI, Unemployment, alimony, child support, pension**
 - c. **Other income (e.g. financial aid, TANF)**
3. **Your most recent checking, savings, stocks, bonds, IRA/CD, cash value of Life Insurance statements**
4. **Address verification, i.e. bill, etc.**

Applicant Name _____ **Date of Birth:** ____/____/____

Daytime phone # _____ **County of Residence** _____

Address _____ **City/State** _____ **Zip** _____

Were you born in the USA? Yes No. If no, what country were you born in? _____

US Citizen? Yes / No **SSN / ITN #** (circle one) _____ - _____ - _____ **Marital Status** S M D Sep Wid **Gender** M / F

Rac/Ethnicity: African American American Indian Asian Caucasian Hispanic Other

Current Employer Name & Phone# _____

Start Date _____ **How long at current job?** _____ years. **Student?** Y N **Where?** _____

What is your education level? ___ Less than high school degree ___ High school degree ___ Some college (associate degree, nursing etc.) ___ College degree (bachelor's degree) ___ Professional and/or Graduate degree (LLB, MA, PhD etc.)

How did you hear about VIM? ___ Through a family member ___ Through a friend ___ At Emergency Room
Other: _____

Other Household Members:

NAME	SS#	Date of Birth	Relationship To Patient	Employer Name
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do you own property other than where you reside? Yes No If yes, do you receive income? Monthly Amt? _____

Copies of the following documents are required.

	<u>Name of Bank/Institution</u>	<u>Account Balance</u>
Checking Account	_____	\$ _____
Savings Account	_____	\$ _____
Cash Value of Life Insurance	_____	\$ _____
Stocks	_____	\$ _____
Bonds	_____	\$ _____
403b/401k	_____	\$ _____
CD's	_____	\$ _____
IRA's	_____	\$ _____

Monthly Expenses: Mortgage/Rent \$ _____ Auto Payments \$ _____
Health Insurance \$ _____ Auto Insurance \$ _____
Child Care/Support \$ _____

I hereby apply for financial assistance. I certify that the information and all statements contained in this application are correct and complete. I understand that the required information must be provided in a timely manner. I understand that if the information is not provided as requested, I will not be eligible as a patient at Volunteers In Medicine (VIM) of Monroe County. I authorize VIM to verify any information contained herein, including obtaining a credit bureau report. I understand that if services from IU Health Bloomington (IUHB) are deemed medically necessary by VIM, I hereby apply for financial assistance with IUHB. I understand that untrue or incomplete information is cause for denial.

Applicant Signature

Date