Reid Health

Main Campus - 1100 Reid Parkway, Richmond, IN 47374
PFS- 600 East Main St, Richmond, IN 47374

APPLICATION FOR PATIENT ASSISTANCE

☐ **I have Health Insurance** ☐ **I do not have Health Insurance**

Patient's Name _____ Home Phone _____
Cell Phone _____
Address _____ Work Phone _____

City_____ State_____ Zip_____ MRN #_____
Patient Assistance Requested By _____

Number of Persons in Household _____

Names of All Persons Living in Household	DOB	Relationship
1. _____		self
2. _____		
3. _____		
4. _____		
5. _____		

(Household income refers to the total of all income from all sources for all persons in the household. These include money wages and salaries before any deductions.)

Monthly Income $_____ Yearly Income $_____
Other Income (Explain) _____

Have you already completed our application for patient assistance, within the last 90 days?
☐ Yes ☒ No

Have you applied for any of the following Health Plans within the last 6 months?
Check all that apply. ☐ Medicare ☐ Medicaid ☐ Disability ☐ Health Indiana Plan (HIP)

I hereby give permission for Reid Hospital & Health Care Services to obtain a credit report.
I affirm the above information is true and correct and I understand evidence of falsification will result in a denial of my application.

_____ _____
Signature of Person Making Request Date