# CHAP

## COMMUNITY HEALTH ASSISTANCE PROGRAM

Your ability to pay for services should not prevent you from receiving the medically necessary care you need. Southern Indiana Community Health Care has a financial patient assistance program in place to help you. All patients receiving essential, medically necessary patient care services at SICHC with a self-pay balance are eligible to apply for financial assistance. In addition to meeting resource guidelines, applicant's family annual income must be within the GROSS (before tax) income qualifications listed below.

This discount ONLY covers office visits. It does NOT cover injections, medications, lab work, or some procedures.

| GROSS INCOME | TOTAL NUMBER IN HOUSEHOLD | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 0-11,770 | 75 | 75 | 75 | 75 | 75 | 75 | 75 | 75 | 75 | 75 |
| 11,771-17,655 | 50 | 75 | 75 | 75 | 75 | 75 | 75 | 75 | 75 | 75 |
| 17,656-23,540 | 25 | 50 | 75 | 75 | 75 | 75 | 75 | 75 | 75 | 75 |
| 23,541-29,425 | 0 | 25 | 50 | 75 | 75 | 75 | 75 | 75 | 75 | 75 |
| 29,426-35,310 | 0 | 25 | 50 | 75 | 75 | 75 | 75 | 75 | 75 | 75 |
| 35,311-41,195 | 0 | 0 | 25 | 50 | 75 | 75 | 75 | 75 | 75 | 75 |
| 41,196-47,080 | 0 | 0 | 0 | 25 | 50 | 75 | 75 | 75 | 75 | 75 |
| 47,081-52,965 | 0 | 0 | 0 | 0 | 25 | 50 | 75 | 75 | 75 | 75 |
| 52,966-88,850 | 0 | 0 | 0 | 0 | 0 | 25 | 50 | 75 | 75 | 75 |

Income= payroll, child support, social security, food stamps, alimony, etc.

To apply for financial assistance or to make budget arrangements, please call 812-723-3944

COMPREHENSIVE HEALTH CARE
420 W LONGEST ST
PAOLI, IN 47454

CRAWFORD COUNTY HEALTH CARE
5604 E WHITE OAK LANE
MARENGO, IN 47140

VALLEY HEALTH CARE
9529 W ST RD 56
FRENCH LICK, IN 47432

PATOKA FAMILY HEALTH CARE
307 S INDIANA AVE
ENGLISH, IN 47118

# CHAP APPLICATION

DATE: ______________________

APPLICANT'S NAME: ______________________ DATE OF BIRTH: ______________

ADDRESS: ______________________

CITY/TOWN: ______________________

PHONE NUMBER: ______________________

TOTAL NUMBER OF MEMBERS IN HOUSEHOLD: ______________

<u>MEMBERS OF HOUSEHOLD:</u>

NAME: ______________________ DATE OF BIRTH: ______________

NAME: ______________________ DATE OF BIRTH: ______________

NAME: ______________________ DATE OF BIRTH: ______________

NAME: ______________________ DATE OF BIRTH: ______________

NAME: ______________________ DATE OF BIRTH: ______________

NAME: ______________________ DATE OF BIRTH: ______________

<u>Yearly gross income</u>, as stated on first page (payroll, child support, social security, food stamps, alimony, etc.)
$ ______________.

I have provided a copy of my most recent tax return and/or my most recent 30 days proof of income. I authorize SICHC to verify eligibility information if necessary, if any of the above information changes, I will notify the office within 30 days. I have agreed that visits not paid at the time of service or within 90 days are at risk of being discharged from the CHAP program.

______________________________________________

Signature of Applicant Date

______________________________________________

Application Approved By: Date

CHAP DISCOUNT EXPIRES 9/30 OF EVERY YEAR, THEREFORE A NEW APPLICATION MUST BE SUBMITTED YEARLY.