INDIANA REGIONAL MEDICAL CENTER
PO BOX 788 INDIANA PA 15701
REQUEST FOR I-CARE FUNDING

APPLICANT NAME, PHONE & ADDRESS: SPOUSE/DEPENDENTS:

SOCIAL SECURITY:

CATEGORY	APPROVAL DATE	EXPIRATION DATE
PATIENT SIGNATURE		EMPLOYEE SIGNATURE

SOURCE OF INCOME FOR YEAR 2010:

	WAGES	YEARLY ESTIMATED INCOME:
	SOCIAL SECURITY	
	SELF-EMPLOYED	2009 FEDERAL TAX RETURN & INCOME VERIFIED BY
	DISABILITY	
	UNEMPLOYMENT	**APPLICATION WILL NOT BE CONSIDERED COMPLETE UNLESS PROOF OF INCOME AND FEDERAL TAX RETURN IS VERIFIED**
	CHILD SUPPORT	
	PENSION	
	OTHER	

I certify that the above information is true and accurate to the best of my knowledge. Further, I will apply for any assistance (Medcaid, Medicare, Insurance, etc.), which may be available for payment of my facility charge, and I will take any action reasonably necessary to obtain such assistance and will assign to or pay the facility the amount recovered for facility charges.

I understand that this application made so the facility can determine my eligibility for uncompensated services under the I-Care fund based on the established criteria on file in the hospital. If any information I have given proves to be false, I understand that the facility may re-evaluate my financial status and take whatever action becomes appropriate. ***Please be aware that you may receive additional billing for services not covered by the I-Care Fund. The I-Care Fund covers Indiana Regional Medical Center billing only.*****

Walk in applications are accepted on Tuesday morning from 8:00 am to 12:00 pm, Wednesday from 8:00am to 3:30 pm and on Thursday from 11:30am to 3:30 pm.

If you have any questions please call:

A-E	724-357-7013
F-K	724-357-7020
L-Q	724-357-7022
R-Z	724-357-8173