# FINANCIAL ASSISTANCE APPLICATION REQUIRED DOCUMENTS

Patients applying for **Financial Assistance** MUST provide the following:

**All sources of income for your household including**:

- Paystub/s (most recent 2 paystubs)
- Bank Statements (last 2 months)
- **Tax Information**:
    - Tax Returns (most recent)
    - W2's
    - Social Security Income Benefit Statement

  **If applicable:**
    - VA Benefits
    - Medicaid Award Letters
    - For Patients who have **Medicare**:
      Enclose a copy of your bills
    - For **"Self-Employed"** Patients:
        - Include a copy of last year's Federal Tax Return and/or
          an Income/Expense Report showing at least the last 4-6 months of activity

## MEDICAID:

Patients applying for **Medicaid** NEED to provide the following:

**Proof of Identification such as:**

- Driver's License
- Birth Certificate

**All types of income, earned and unearned including**:

- Paystubs (most recent 2 paystubs)
- Retirement Benefits
- Social Security Statements
- Income Tax Returns

**Proof of resources:**

- Bank Statements (last 2 months)
- Insurance Policies
- Property – Property Tax Bill or copy of Deed

**Proof or Residence:**

- Rent Receipt
- Landlord Statement
- Deed
- Car Registration

ST. JOSEPH
Regional Medical Center

# Financial Assistance Application

## Patient Information

Name: _____
First M.I Last

Address: _____
Street City State Zip Code

Phone Number: _____ Martial Status: ☐ Single ☐ Married

Date of Birth: _____ Social Security: _____

## Spouse Information

Note: If the patient/guarantor is married, then spouse's financial information and signature are required in order to process this application.

Name: _____
First M.I Last

Address: _____
(if different tahn above)
Street City State Zip Code

Phone Number: _____ Social Security: _____

Date of Birth: _____

### Dependents

| Name | Relationship | Date of Birth |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Household Information

| | | |
|---|---|---|
| Are you in school? | ☐ Y | ☐ N |
| Do You have Health Insurance? | ☐ Y | ☐ N |
| Is insurance offered by school or work? | ☐ Y | ☐ N |
| Do you have Medicare | ☐ Y | ☐ N |
| Do you have Medicaid? | ☐ Y | ☐ N |
| Do you receive veterans benefits? | ☐ Y | ☐ N |

## Employment and Insurance Information

| | Employer |
|---|---|
| Applicant: | |
| Co-Applicant: | |

## Total Household Annual Income

Comment:

Gross Wages: $ _____

Applicant/Co-Applicant

Comment:

Other Wages: $ _____

i.e. Child support, Tips, Rental income, Veterans benefits, Trust, SSI/Disability

# Acknowledgement

I hereby acknowledge that the information in this application (including any attachments) is true, complete and accurate to the best of my knowledge. Furthermore, I understand that to qualify for Financial Assistance, I must take all steps necessary to apply for and obtain any other available payment sources (such as Medicaid, Medicare, insurance, etc.).

I hereby authorize St. Joseph Regional Medical Center to contact any person, firm or organization to verify any of the information given, and I hereby authorize any such person, firm or organization to release such information to St. Joseph Regional medical Center (see attached for facility address). I also authorize St. Joseph Regional medical Center to request a consumer credit report.

Applicant Signature: _____

Date

Co-Applicant Signature: _____

Date

***We will not be able to process a charity application without all of the necessary documents.***

e.g. 2 bank statements, 2 pay stubs, tax returns, other income received (e.g. child support, social security, alimony),If you have no income, provide a letter or a comment below from you stating your source for paying living expenses. **Please allow 30 days for processing**

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## For Internal Use Only

Processed By: _____ Date: _____

Financial Counselor

Eligibility Determination: (  ) Yes (  ) No Discount: _____ %

Justification:

Reviewed/Approved By: _____

Financial Services Director Date

_____

Hospital Controller/CFO Date

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