Ascension

[Date]

Dear Patient/Applicant,

Ascension is driven by compassion and dedicated to providing personalized care for all – especially those most in need. It is our mission and privilege to offer financial assistance to our patients. Financial assistance is available only for emergency and other medically necessary care. Thank you for trusting us to care for you and your family for all of your healthcare needs.

We are sending this letter and the attached financial assistance application because we received your request. If you did not request this, please disregard. Please complete both sides, including your signature and date before returning it. If you completed an application within the past six months and were approved for financial assistance, please notify us – you may not need to complete a new application. Unfortunately, we are unable to rely on a prior application that is greater than six months old.

Along with the application, you will need to provide verification of your household's income and verification of all assets owned by any household member.

Examples of proof of income and assets include:

- Copies of 3 most recent paystubs from employer
- Copies of most recent yearly tax return (if self-employed, include all schedules)
- Social Security and/or Pension Retirement Award Letter
- Parent or guardian's most recent yearly tax return, if applicant is a dependent listed on their tax form and under the age 25
- Copy of receipt of unemployment benefits
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance
- Other income validation documents

Examples of proof of assets include:

- Current bank statements (checking and savings accounts) from last 3 months
- Investments, including stocks and bonds
- Trust funds
- Money market accounts
- Mutual funds

Finally, we may be able to consider your outstanding medical bills to qualify you for financial assistance. If you would like for us to consider this, please also provide documentation of your outstanding monthly medical and pharmacy/drug costs, such as current invoices or statements of account balances. **Please know that the 1) completed application along with 2) proof of income, 3) assets, and 4) outstanding medical bills (if applicable) must be received in order for the application to be considered. We are unable to process or consider applications that are not complete.**

When submitting your application, please keep in mind that communications via email over the internet are not secure. Although it may be unlikely, there is a possibility that information you include in an email may be intercepted and read by other parties besides the person to whom it is addressed. We want to protect your personal information and ensure that it remains secure. Since the application contains your social security number and other private information, we urge you to refrain from emailing it.

Please print and mail your completed application and supporting documentation to the following address:

For Hospital Accounts:
Ascension Sacred Heart
PO Box 946891
Atlanta GA 30394

For Medical Group Accounts:
Attn: Lockbox 713441
3441 Reliable Pkwy
Chicago, IL 60686

We are here to help and want to ensure that patients that qualify for financial assistance receive it. If you have any questions about this application, supporting documents required, or how to best get your application to us, please call one of our Patient Representatives at 866-869-9677

Sincerely,

Patient Financial Services
Ascension

Financial assistance application form



Ascension

Patient information

(Please print and all fields must be completed. Indicate N/A if not applicable on any individual line in the application.)

Date _____ Account number _____

Name (first and last) _____

Birth date _____ Marital status _____ Phone number _____

Mailing address _____ City _____ State _____ ZIP _____

Social security number (optional) _____

Employer _____ Employment status _____

Number of hours worked per week _____ Employer phone number _____

Responsible party's information/legal guardian's information

(If patient above is same as responsible party, leave this section blank.)

Name (first and last) _____

Birth date _____ Marital status _____ Phone number _____

Mailing address _____ City _____ State _____ ZIP _____

Social security number (optional) _____

Employer _____ Employment status _____

Number of hours worked per week _____ Employer phone number _____

Responsible party spouse information

(If patient is same as responsible party, fill in spouse information for patient.)

Name (first and last) _____

Birth date _____ Marital status _____ Phone number _____

Mailing address _____ City _____ State _____ ZIP _____

Social security number (optional) _____

Employer _____ Employment status _____

Number of hours worked per week _____ Employer phone number _____

Dependents of responsible party

(If patient is same as responsible party, fill in spouse information for patient.)

Name _____ Birth date _____ Relationship to responsible party _____

Name _____ Birth date _____ Relationship to responsible party _____

Name _____ Birth date _____ Relationship to responsible party _____

Name _____ Birth date _____ Relationship to responsible party _____

Number of adults and children living in household _____

Monthly income

(Fill in dollar amounts for each item listed below. Provide amount per month for each.)

Applicant earned income _____
Applicant spouse income _____
Social Security benefits _____
Pension/retirement income _____
Disability Income_____
Unemployment Compensation _____
Worker's compensation _____
Interest/dividend income _____

Child support received _____
Alimony received _____
Rental property income _____
Food Stamps _____
Trust fund distribution received _____
Other Income _____
Other Income _____
Total **gross monthly income $** _____

Monthly living expenses

Mortgage/rent_____
Utilities_____
Phone (landline) _____
Cell phone _____
Groceries/food_____
Cable/internet/satellite tv _____
Car payment _____
Child care _____

Child support/alimony _____
Credit cards _____
Doctor/hospital bills _____
Car/auto insurance _____
Home/property insurance _____
Medical/health insurance _____
Life insurance _____
Other monthly expense _____
Total monthly expenses $ _____

Assets

Cash/savings/checking accounts _____
Stocks/bonds/investments/CD(s)_____ Other real estate/secondary residence _
Boat/RV/motorcycle/recreational vehicle _____
Collector automobiles/non-essential automobiles _____
Other assets _____

I hereby certify that the above information is true and complete to the best of my knowledge. I hereby authorize the hospital to obtain information from external credit reporting agencies if the hospital deems necessary.

Signature of Applicant _____

Date _____

Comments _____