CONFIDENTIAL APPLICATION FOR HOSPITAL FINANCIAL ASSISTANCE

Professional services provided by affiliated physicians or other providers may be billed separately.
Application of Financial Assistance is at the discretion of those providers in accordance with their policies, procedures, and applicable regulations.
The information provided in this application may be provided to affiliated providers to assist the patient.

Patient Name		Date of Birth	
Street Address		Telephone	Msg Phone
City/State/Zip		Social Security Number	
Mailing Address (if different)			

Ethnicity and Race (Optional)

Are you Hispanic or Latino?	☐ Yes ☐ No ☐ Decline
	☐ American Indian / Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ White ☐ Black/African American ☐ Multiracial ☐ Decline
Preferred Language	Written: / Spoken:

Please provide the following for all household members:

Name	Date of Birth	Relationship to Patient

Application

Do you have insurance?	☐ No	☐ Yes	If Yes, Name/ID	
Do you have Medicaid?	☐ No	☐ Yes	If Yes, Name/ID	
Do you receive assistance with medical bills?	☐ No	☐ Yes	If Yes, Name/ID	
Do you have Medicare?	☐ No	☐ Yes	If Yes, Name/ID	
Have you applied for Disability?	☐ No	☐ Yes	If Yes, When?	
Is anyone in the household a veteran?	☐ No	☐ Yes	If Yes, Name?	
Is there a member of the household who became unemployed within the past 90 days?	☐ No	☐ Yes	If Yes, Name?	

Were health benefits received by this person?	☐ No	☐ Yes	If Yes, Name of insurance company?	
If you answer Yes to any of the questions below you will need to apply for Medicaid before being eligible for Financial Assistance				
Are you 65 years of age or older?	☐ No	☐ Yes		
Are you pregnant now or have you been in the last 3 months	☐ No	☐ Yes		
Are you blind or disabled?	☐ No	☐ Yes		
Are you a parent or close relative living with and acting as a parent for a child under the age of 18?	☐ No	☐ Yes		

Assets

Cash on hand (Countable)	Bank:	$
Checking Account Balance (Countable)	Bank:	$
Savings Account Balance (Countable)	Bank:	$
Investments or Other Securities (Countable)		$
Retirement Savings	Bank:	$
Life Insurance Policy Cash Value		$
Real Estate other than Primary Residence	Location:	$

Total Countable Assets: $ ____________

List vehicles owned below: (include cars, trucks, snowmobiles, RVs, motorcycles, etc.)

Type of Vehicle	Year	Value
		$
		$
		$

Total Assets: $ ____________

Employment

Person Employed	Employer	Gross Pay	Per:	Monthly Gross
			☐ WK ☐ 2WK ☐ Month	$
			☐ WK ☐ 2WK ☐ Month	$
			☐ WK ☐ 2WK ☐ Month	$
			☐ WK ☐ 2WK ☐ Month	$
			☐ WK ☐ 2WK ☐ Month	$

Monthly Household Income from Other Sources

Source	Monthly	Annually
Child Support / Alimony	$	$
Federal Assistance Program Type ____________ (ie Cash, Food Stamps etc.)	$	$
Pension / IRA / 403(b) / Annuity Cashout	$	$
Social Security / Social Security Disability	$	$
Unemployment or Workers Comp End Date:)	$	$
Other Income (Stocks/Bonds/Annuities/Interest/Rental Property)	$	$
Total Monthly Gross Income from Other Sources	$	$

Monthly Household Liabilities/Expenses

Type of Expense	Total Monthly:	Past Due Balance:	Annually For Office Use Only
Rent / Mortgage, Balance: _______________	$	$	$
Grocery Expense	$	$	$
Child Care	$	$	$
Child Support / Alimony	$	$	$
Utilities: Gas ___________ Electric ___________ Water / Sewer __________ Other _____________	$	$	$
Telephone: (Mobile/Cell/Home etc.)	$	$	$
Medication Expenses (co-pay / cash pay etc.)	$	$	$
Unpaid Medical Expenses (i.e. doctor, dental, hospital, other providers) Please provide a detailed list with copies of most recent bills if available	$	$	$
Insurance Premiums: Health_____________ Auto ______________ Home_____________	$	$	$
Car Loan Payments Balance Owed $ _______________	$	$	$
Transportation (Bus, Taxi)	$	$	$
Loan Payment Type:__________________ Balance:____________	$	$	$
Credit Card Payment(s) Total Balance(s) Owed: _________________________		$	

VERIFICATION OF INCOME AND IDENTIFICATION

I hereby authorize Trinity Health (Saint Francis Healthcare and affiliate provider offices) to release information on file to assist in the enrollment of various health and human service programs for which I apply. I understand this information may includefinancial information, medical information and/or any other information contained in my file.

The U.S. Department of Health and Human Services (HHS) enforces the federal privacy regulations commonly known as the HIPAA Privacy Rule (HIPAA). HIPAA requires most doctors, nurses, pharmacies, hospital, nursing homes and other health care providers to protect the privacy of your health information. Even though HIPAA requires health care providers to protect your privacy, providers are permitted, in most circumstances to communicate with the patients family, friends, or others involved in their care or payment for care.

I authorize Trinity Health to use the information provided on my Medicaid application to determine my eligibility for financial assistance. I understand that I may be asked to provide additional information and documentation to complete my financial assistance application

I certify that the information listed in this application is true and complete to the best of my knowledge. I understand that the information provided will be verified and treated as personal and confidential. I also understand that I will be liable for repayment of any services rendered at Trinity Health affiliates if the above information is given under false pretenses.

SIGNATURE ___________________________________ ☐ Signature on File DATE ____________

SPOUSE SIGNATURE (If applicable) _________________ ☐ Signature on File DATE ____________