ASCENSION Medical Group

Sacred Heart Medical Group PROVIDENCE Medical Group

Sacred Heart Health System, Inc
aka Sacred Heart Medical Group
aka Panhandle Emergency Physicians

Providence Health System, Inc
aka Providence Medical Group
aka Seton Medical Management

Dear Patient/Guarantor:

You have indicated that you need assistance with your hospital bill. In order for us to evaluate your financial situation, the following doucments are required:

- A completed Financial Evaluation Form (enclosed);
- A copy of your most current Federal tax form(s) with ALL schedules, including W-2(s);
- A copy of your most recent three (3) paycheck stuffs for you and anyone working within your household:
- A copy of your most recent three (3) bank statements for each account that you have;
- A list of your outstanding medical debts and monthly pharmacy costs; and the name and telephone number for your Medicaid caseworker, if applicable;
- Other: _____

You can reach the Financial Assistance Department by calling 800-566-5050 should you have any questions and/or concerns. **Please be advised that if the information requested is not received within the next 30 days, we will continue our normal billing practice**. All documentation should be sent to the address listed below or you can fax this information. Thank you for your cooperation.

Fax:

(317) 583-2753
Attn: NRSC Financial Assistance Representative

Mail:

NRSC Financial Assistance Representative
10330 N. Meridian Street, 2N PFS
Indianapolis, IN 46290

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Financial Evaluation Form

MR Number & Account Number to be completed by hospital personnel	*MR Number:*	*Hospital*	*Account Number:*

Please provide the following information completely and accurately. Information is subject to verification.
Please attach a list of additional household members if there are more than five (5) members.

Patient's Name (First, MI, Last):	Social Security Number:	Total # Household Members
Address:	Telephone Numbers: Home: ( ) Work: ( )	
City/ST/Zip:	Responsible Party Name (First, MI, Last):	

List ALL household member names	**Date of Birth**	**Soc Sec Number**	**Relationship to patient**	**Monthly Income**
1.		- -		**$**
2.		- -		**$**
3.		- -		**$**
4.		- -		**$**
5.		- -		**$**

Monthly Income		**Monthly Expenses**	
Responsible Party's Gross Income (before taxes)	**$**	Rent/Mortgage/Homeowner's Insurance	**$**
Other Household Gross Income (before taxes)	**$**	Utilities (Electricity/ Water/Gas)	**$**
Investment Income (Annuities/Stocks/Dividends)	**$**	Telephone	**$**
Child Support/Alimony Received	**$**	Child Support/Alimony Paid	**$**
Rental Property Income	**$**	Food (excluding cigarettes & alcoholic beverages)	**$**
Pension/Retirement/Unemployment	**$**	Car Payment (loan + insurance)	**$**
Other:	**$**	Medical & Pharmacy Bills	**$**
Total Monthly Income (before taxes)	**$**	**Total Monthly Expenses**	$
Assets		**Liabilities**	
Value of Residence(s)	**$**	Residence Loan Balance/Mortgage	**$**
Checking Account Balance	**$**	Balance Owed on Credit Cards	**$**
Savings/Money Market/CD's/Retirement Funds	**$**	Auto Loan Balance	**$**
Value-Auto/Boat/Motorcycle	**$**	Total Medical Bills (attach list)	**$**
Other:	**$**	Real Estate Taxes	**$**
Total Value of Assets	**$**	**Total Liabilities**	**$**

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at time of registration. I understand that providing false information will result in denial of the application for any type of financial assistance through the Organization. If I am entitled to any action against or settlement from third party payers, I will take any action necessary or requested by the Organization to obtain such assistance and will assign to the Organization, and upon receipt will pay the Organization, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by the Organization will result in the denial of this application. I also authorize the Organization to check my credit history through the credit bureau, if deemed appropriate.

_____ _____

Signature of Patient (Responsible Party) Date