Ascension St. Vincent's

Health Outreach Patient Eligibility (H.O.P.E)

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. We will not consider a prior application that is greater than six months old.

Along with the application, please provide a copy of at least one of the following items as your proof of income. If you are married or have lived with a significant other for 6 months or longer, they will also need to provide a copy of at least one of the following items as proof of their income before the application can be processed.

- Copies of 3 most recent paystubs from employer
- Copies of most recent yearly tax return (if self-employed, include all schedules) or verification of non-filing (www.irs.gov/form 4506-T)
- 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
- Other income validation documents
- Copies of bank statements from last 3 months
- Copy of receipt of unemployment benefits

If you receive assistance from or live in a home with a family or friends, please have them complete the attached form labeled "Letter of Support" and include the copy of their photo ID. This will not make them responsible for your medical bills. This will help show how you are able to afford living expenses. If you receive no assistance from family and friends, you do not need to fill out the Letter of Support form.

Finally, please also provide documentation as proof of your outstanding monthly medical and pharmacy/drug costs.

Please know that the completed application along with proof of income must be received in order for the application to be considered. We are unable to process or consider applications that are not complete.

Please keep in mind that communications via email over the internet are not secure. Although it is 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 or hand deliver your completed application to one of the following addresses:

ASCENSION ST. VINCENT'S RIVERSIDE
HOPE PROGRAM
1 SHIRCLIFF WAY
JACKSONVILLE, FL 32204

ASCENSION ST. VINCENT'S SOUTHSIDE HOPE PROGRAM
4201 BELFORT RD
JACKSONVILLE, FL 32216

ASCENSION ST. VINCENT'S CLAY COUNTY
HOPE PROGRAM
1670 ST. VINCENT'S WAY
MIDDLEBURG, FL 32068

ASCENSION ST. VINCENT'S ST JOHNS COUNTY
HOPE PROGRAM
205 TRINITY WAY
ST. JOHNS FL 32259

If you have any questions about this application, please call one of our Patient Representatives at (904) 308-1956.

Sincerely,

Patient Financial Services
Ascension St. Vincent's

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Financial Assistance Additional Screening Questions

Do you have health insurance?	Y N	Insurance Company Name and Member ID_____
Are you under 21 or over 65 years old?	Y N	☐Under 21 ☐Over 65
Do you have minor children at home?	Y N	
Are you pregnant?	Y N	
Have you been deemed disabled by Social Security Administration or Do you have a disability case pending?	Y N	☐Disabled ☐Pending: when did you apply?
What is your US citizenship status? *Please note: this question is asked for Emergency Medicaid eligibility purposes only*	Y N	☐US citizen ☐ Refugee ☐Green Card ☐VISA (work or visitor)

Please indicate the reason you are applying for Financial Assistance/HOPE

☐ **I have outstanding medical bills due to Emergency Room visit / Inpatient Stay / Scheduled care (circle one or more answers)**

☐ **Other (please provide brief explanation) _____**

Application Processing Time

- **May take up to 45 days but our Financial Counselors are working diligently to process your application as quickly as possible.**

- **To aid our Financial Counselors with the process, please ensure that you submit fully completed and signed application and with all required documents to avoid delays in your application processing.**

Health Outreach Patient Eligibility (H.O.P.E)

Financial Assistance Application Detailed Instructions

☐ **Financial Assistance Application Form**
Please complete all applicable fields, sign and date

☐ **Financial Assistance Screening Questions**
Please circle Yes or No and provide additional information where needed

☐ **Letter of Support**
Please complete if applicable to you

☐ **Homeless Attestation Form**
Please complete in full if applicable to you

☐ **Financial Information Release, Form 2613 (FL residents only)**
This form is to be used for Medicaid eligibility and determination purposes by DCF (Department of Children and Families) and if you are eligible.
Signature lines must include patient's and spouse's signature if applicable.

☐ **Appointment of Designated Representative, Form 2505 (FL residents only)**
Sign and date on *Signature of Customer* Line.
This form is to be used for Medicaid eligibility and determination purposes. It allows us to complete your Medicaid application and follow up on your Medicaid case. Do not enter a name for the representative.

☐ **Attachment C (GA residents only)**
Sign your name under 10. and date under 11.

☐ **R1 Authorization for Patient Representation**
Sign and date.

☐ **R1 Authorization to Discuss Health Care Coverage**
Please complete requested information if applicable to you.

Financial assistance application form

Health Outreach Patient Eligibility (H.O.P.E)

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 _____

Ascension St. Vincent's

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Letter of support

Patient medical record number/account number_____

Supporter's name_____

Relationship to patient/applicant _____

Supporter's address _____

To Ascension:

This letter is to advise that(patient's name)_____receives little to no income and I am assisting with his/her living expenses. He/She has little to no obligation to me.

By signing this statement, I agree that the information given is true to the best of my knowledge.

Signature of supporter_____

Date _____

Ascension St. Vincent's

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HOMELESS ATTESTATION FORM

Patient Name:_____DOB: _____

Last 4 of SSN:_____SSN Verified (Y/N): _____

☐ I am currently a homeless individual and am allowed to receive mail at the following address:

_____

_____

☐ I receive food stamps in the amount of $_____per month.

☐ I am unemployed and have had no income for the last_____months.

PATIENT

I hereby attest that my response to the applicable preceding statement is true, complete and accurate. By signing this Attestation, you certify that you have read this Attestation or that it has been read to you and applied a valid, legal signature.

_____ _____ _____

Patient Signature Date Phone Number

Homeowner/Leasee

Please have the homeowner/leasee of the home where you are allowed to receive mail complete this section:

I_____attest that_____is currently homeless and is allowed to receive mail at my home address listed above.

_____ _____ _____

Resident Signature Date Phone Number

State of Florida
Estado De La Florida

Department of Children and Families
Departamento de Ninos y Familias

FINANCIAL INFORMATION RELEASE

Autorizacion Para Informe Economico

Date *(Fecha):*_____

_____
Case Number or ACCESS Number
(Numero def Caso o Numero de ACCESS)

To Whom It May Concern:
(A Quien Pueda Interesar):

I hereby grant permission and authorize any bank, building association, employer, insurance company, real estate company, government agency or any financial institution of any kind or character to disclose to any agent of the Department of Children and Families full information as to my bank accounts, earnings, insurance policies, property or benefits, for the time period listed below.

(Par la presente autorizo a cua/quier banco, compafiia de construcci6n, compafiia de seguros, compafiia de bienes raices, agencia de gobierno o instituci6n financiera que a sf lo solicite, a suministrar informaci6n sabre mis cuentas bancarias, ingresos, polizas de seguro, propiedades o beneficios, par el periodo de tiempo abajo indicado, a cualquier empleado de/ Departamento de Ninos y Familias.)

This release is valid from_____to_____

(Esta autorizaci6n es valida desde_____hasta_____.)

Signature(s): _____
(Firma(s))

_____

Name(s) on Account: _____
(Nombre(s) en la Cuenta)

_____

_____ _____
ESS Specialist Signature Date

Clear

APPOINTMENT OF A DESIGNATED REPRESENTATIVE

Case Number

Customer's Name

Completed by Customer

I would like for _____ to act on my behalf in determining my
Name of Representative

eligibility for public assistance from the Department of Children and Families.

Signature of Customer

Date

Completed by Representative

I understand that by accepting this appointment, I am responsible to provide or assist in providing information needed to establish this person's eligibility for assistance. I understand that I may be prosecuted for perjury and/or fraud if I withhold information or intentionally provide false information.

Signature of Representative

Date

Relationship to Customer

Street Address

City

State

Phone Number

Self-Appointment by Representative

I am acting for _____ in providing information to establish eligibility for assistance because he/she is unable to act on his/her own behalf. I will provide information to the best of my knowledge. I understand that if I withhold information or if I intentionally provide false information, I may be prosecuted for perjury and/or fraud. I agree to immediately report any change in their situation of which I become aware.

Signature of Representative

Date

Relationship to Customer

Street Address

City

State

Phone Number

ATTACHMENT C

GEORGIA DEPARTMENT OF HUMAN SERVICES
Division of Family and Children Services

PeachCare for Kids®

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Form Approved
OMB No. 0938-1191

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact Division of Family and Children Services (DFCS) at 1-877-423-4746. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number ( ) –		
8. Organization name		9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature	11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)

NEED HELP WITH YOUR APPLICATION? Visit Compass.ga.gov or call us at **1-877-423-4746**. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. If you need help in a language other than English, call **1-877-423-4746** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-255-0135**.

AUTHORIZATION FOR PATIENT REPRESENTATION

FROM: (CLIENTS NAME) _____

I hereby designate and appoint R1 Care Coverage, its agents and employees (collectively "Representatives") to represent me and act in my behalf before any medical institution, financial institution, life insurance company, place of employment, county/state Department of Human Services, the Social Security Administration, mental health institution and the Veterans Administration for the purpose of potentially securing or modifying healthcare benefits for me and/or my household.

I expressly consent to the disclosure and release to my Representatives of all hospital records, medical and psychiatric reports (including, if appropriate, reports relating to drug, alcohol, and HIV/AIDS), all financial information (including bank statements, life insurance policies, and employment/payroll documentation) and all other documents and information pertaining to me and/or my household which are in the custody of these entities.

I understand that some of the records retrieved may include information about substance abuse, mental health and HIV status with regards to other communicable disease infection. Some of this information must be kept confidential pursuant to all state and federal laws with HIPAA privacy regulation as modified August 14, 2002. I certify that I have received a copy of the R1 Notice of Privacy Policy as required by law.

I hereby waive any confidentiality requirements assessed by representatives of R1's Care Coverage, and will only disclose this information to others with direct relation to my case. The information retrieved or disclosed shall have the duration of no longer than what is reasonable to achieve this information and its disclosure.

SOCIAL SECURITY DATA: I also authorize and assign to R1's Care Coverage the right to gather information from the Social Security Administration and/or legal counsel that I have obtained in order to validate or obtain my information of any family member related to my case which I and any of my family members are receiving.

_____ _____ _____

Name (print) **Signature** **Date**

_____

Street Address

_____ _____ _____ _____

City **State** **Zip** **Phone**

Ascension St. Vincent's

_____ _____

Hospital / Admit Date **Witness Signature (if patient unable to sign)**

_____ _____

Care Coverage Representative **Account Number**

INSTRUCTIONS: Please provide two additional contacts that R1 RCM Inc. can speak to on your behalf regarding your health insurance/Medicaid/Medicare case:

AUTHORIZATION TO DISCUSS HEALTH CARE COVERAGE

I hereby authorize R1 RCM Inc. to use or disclose information related to my health care coverage with the individuals listed below. This authorization will be in effect until health care coverage is approved, a final determination is made that I am not eligible for any health care coverage, or I withdraw this authorization by providing written notice to R1 RCM Inc.

Name: _____

Relationship to Patient: _____

Phone: _____

Name: _____

Relationship to Patient: _____

Phone: _____

_____ _____ _____

Patient Name (print) **Signature** **Date**

_____ _____ _____

Authorizing Person if other than Patient **Signature** **Date**

_____

Street Address

_____ _____ _____ _____

City **State** **Zip** **Phone**

Ascension St. Vincent's

_____ _____

Hospital / Admit Date **Witness Signature (if Patient unable to sign)**

_____

R1 RCM, Inc. Representative