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)
- 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." 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 the following address:

300 Great Circle Road
Nashville, TN 37228

If you have any questions about this application, please contact Kami Morgan at 629-216-2163.

Sincerely,

Patient Financial Services
Ascension

Financial assistance application form

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 ________________________

Ascension Saint Thomas

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 ______________________

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 _________________________________