Dear Patient/Guarantor:

Thank you for choosing Sacred Heart Health System for your healthcare needs. It is our mission and privilege to offer financial assistance to our patients.

At your request we have provided the attached Financial Evaluation Application. In order to evaluate your financial situation, documents are required in addition to your completed and signed Application. If you are married, proof of income will also be required for your spouse before the application can be processed. Please submit the following:

- Completed and signed **Financial Evaluation Form** (enclosed); **AND**

- A copy of your three (3) most recent paycheck stubs showing total earnings (before taxes) for you and you spouse (if applicable), and proof of any other income received in the household (retirement, Social Security, child support, etc). **AND**

- A copy of your most current Federal tax return including W-2(s). If self-employed, please include all schedules with your return. If you did not file taxes last year, you must submit a letter stating that you did not file and why. **OR**

- Other: If you receive assistance from or live in the home with family or friends, please have them complete the attached form labeled “Letter of Support”. This will NOT make them responsible for your medical bill. This will only serve to show how you are able to afford living expenses. If you receive no assistance, the Letter of Support does not need to be completed. **AND**

- Your Medicaid case number, if applicable. If minor children are in the home, you must submit valid Medicaid denial for income or assets. This is required even if the patient has health insurance. Failure to cooperate with child support is not a valid denial. Financial Assistance applicants must comply with screening and application requirements for public assistance (for example Medicaid) in order to be eligible for Financial Assistance.

The completed application along with proof of income must be received in order to complete the evaluation process. Allow 30 days for processing once all documents are returned. Incomplete applications will not be processed. **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 returned to:

Sacred Heart Health System
Patient Financial Services
PO Box 2488
Pensacola, FL 32513-2488

If you have any questions, please call Customer Service at 1-866-869-9677.

Sincerely,
Patient Financial Services
Sacred Heart Health System

Financial Evaluation Application

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.

Patient's Name (First, MI, Last):	Social Security Number:	Marital Status
Address:	Telephone Numbers: Home: ( ) Work: ( ) Cell: ( ) E-mail address:	
City/ST/Zip:	Responsible Party Name (First, MI, Last):	

List all members in the household. Household members are defined as Patient, Spouse, minors and tax dependents. Do not include non-relatives, roommates or extended family. Attach a list of additional household members if there are more than five (5) members.

List ALL household member names	**Date of Birth**	**Social Sec Number**	**Relationship to patient**	**Monthly Income**
1. **PATIENT**		- -	**SELF**	$
2.		- -		$
3.		- -		$
4.		- -		$
5.		- -		$
Total Household Size				

Monthly Income		**Monthly Expenses**	
Responsible Party's Gross Income (before taxes)	$	Rent/Mortgage/Homeowner's Insurance	$
Social Security Benefits	$	Utilities (Electricity/ Water/Gas/Garbage)	$
Spouse/Other Household Gross Income (before taxes)	$	Telephone/Cell/Internet/Cable	$
Investment Income (Annuities/Stocks/Dividends/Interest)	$	Car Payment (loan + insurance)	$
Child Support/Alimony Received	$	Food (excluding cigarettes & alcoholic beverages)	$
Rental Property Income	$	Medical & Pharmacy Bills	$
Pension/Retirement	$	Child Support/Alimony Paid	$
Unemployment/Workers Compensation	$	Day Care	$
Other:	$	Student Loan	$
		Other:	$
Total Monthly Income (before taxes)	$	**Total Monthly Expenses**	$

Comments____

I certify that the information provided above is an accurate and true representation of my financial information. I understand that providing false information will result in denial of the application. My failure to apply for such assistance or to follow through with the application process will result in the denial of this application. I authorize Sacred Heart Health System to check my credit history through the credit bureau, if deemed appropriate.

____ ________________________________

Signature of Patient (Responsible Party) Date

Financial Assistance Letter of Support

To be completed by the person(s) providing patient's support

Patients, spouses or families reporting limited, zero or lapse of income are required to have the person(s) supporting them complete this letter.

Patient's name:______________________________ Account Number:___________________________

I, ____________________________ (print name) provide the following support without charge or exchange

to the above person. I have provided support since:_________________ ____________________

Begin Date End Date

Please check everything that you supply below:

_________ Housing
_________ Food
_________ Expenses and personal items (estimated monthly amount) $____________.
_________ The patient is my spouse and I am sole support of the household.

I understand that by signing this letter of support for the above named patient it does not obligate me to pay for medical services provided to the patient from Sacred Heart Health System. The purpose of this letter of support is to assist the patient in qualifying for potential funding solutions under the Hospital's Financial Assistance Program.

Signature:__________________________ Date:___________Telephone#___________________________

Letter of Support/Verification of Lapse of Income

Needs to be completed by someone other than the person that completed the letter above

To the best of my knowledge,____ has had no income from

___________ ____________. He/She is being financially supported by _________________________.

Begin Date End Date

I understand that by signing this letter of support for the above named patient it does not obligate me to pay for medical services provided to the patient at Sacred Heart Health System. The purpose of this letter of support is to assist the patient in qualifying for potential funding solutions under the Hospital's Financial Assistance Program.

Signature:___________________________ Date:_______________ Telephone#____________________