Ascension Saint Thomas

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.

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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 mail or fax your application to the appropriate location. For the phone number of your provider or fax/mailing address where applications should be submitted please refer to the next page of the application.

Sincerely,

Patient Financial Services Ascension

Ascension Saint Thomas

| Provider Name | Phone Number | Address | Fax Number | Email Address |
|---|---|---|---|---|
| Saint Thomas West | (615) 222-6638 | STHe Financial Asst.<br>PO Box 380<br>Nashville, TN 37202 | (629) 204-6542 | |
| Saint Thomas Midtown | (615) 284-5340 | STHe Financial Asst.<br>PO Box 380<br>Nashville, TN 37202 | (629) 204-6540 | |
| Saint Thomas Rutherford | (615) 222-6638 | STHe Financial Asst.<br>PO Box 380<br>Nashville, TN 37202 | (629) 204-6541 | |
| Ascension Medical Group | (844) 686-2555 | STH Financial Asst<br>PO Box 80278,<br>Indianapolis, IN 46240 | (317) 981-6312 | FinancialCounselors@ascension.org |
| Saint Thomas Highlands | (877) 348-7082 | STHe Financial Asst.<br>401 Sewell Dr,<br>Sparta, TN 38583 | (931) 738-2669 | |
| Saint Thomas Dekalb | (877) 348-7082 | STHe Financial Asst.<br>401 Sewell Dr,<br>Sparta, TN 38583 | (931) 738-2669 | |
| Saint Thomas River Park | (877) 348-7082 | STHe Financial Asst.<br>401 Sewell Dr,<br>Sparta, TN 38583 | (931) 738-2669 | |
| | | | | |
| Saint Thomas Stones River | (877) 348-7082 | STHe Financial Asst.<br>401 Sewell Dr,<br>Sparta, TN 38583 | (931) 738-2669 | |
| Saint Thomas Hickman | (931) 729-6800 | STHe Financial Asst.<br>135 E. Swan Street<br>Centerville, TN 37033 | | |
| Lab Plus | (615) 284-2773 | Lab Plus LLC Attn:<br>Billing Dept 2000<br>Church Street<br>Nashville, TN 37236 | (615) 284-2771 | |
| Saint Thomas Center for Specialty Surgery | (615) 341-7500 | STHe Financial Asst.<br>2011 Murphy Ave<br>Suite 400<br>Nashville, TN 37203 | (615) 341-7513 | STHSSFinAssist@uspi.com |
| Saint Thomas EMS | (877) 664-4076 | STHe Financial Asst.<br>PO Box 681787<br>Franklin, TN 37064 | (615) 236-4040 | |
| Baptist Ambulatory Surgery Center | (615) 321-7330 | STHe Financial Asst.<br>312 21st Ave. North<br>Nashville, TN 37203 | (615) 320-5319 | |
| Saint Thomas Center for Sleep | (615) 222-6638 | STHe Financial Asst.<br>PO Box 380<br>Nashville, TN 37202 | (615) 222-7700 | |

# Ascension Saint Thomas 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 _____

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## 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** _____

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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 _____