



# Ascension

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:

**Ascension Seton - Patient Financial Services**  
**Attn: Financial Counselors**  
**P.O. Box 204398**  
**Dallas, TX 75320-4398**  
**512-324-1125**

**Ascension Medical Group**  
**Attn: Financial Assistance Department**  
**P.O. Box 80278**  
**Indianapolis, IN 46240-9998**  
**512-324-8960**

If you have any questions about this application, please call one of our Patient Representatives.

Sincerely,

Patient Financial Services  
Ascension

# Financial assistance application form



**Ascension  
Seton**

## 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**

# 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 \_\_\_\_\_