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**
- **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:

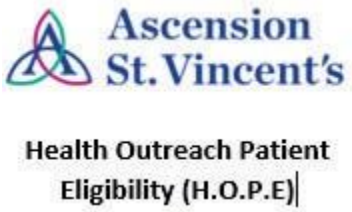
Ascension St. Vincent's
Medical Group
HOPE Program
(904) 308-7864
Fax Number: (904) 450-6448

If you have any questions about this application, please call one of our Patient Representatives at (904) 308-7864.

Sincerely,

Patient Financial Services
Ascension St. Vincent's

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 (for billing and identification purposes only)_____

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 (for billing and identification purposes only)_____

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 (for billing and identification purposes only)_____

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 _____

Trust fund distribution received _____

Other income _____

Other income _____

Total gross monthly income $_____

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

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

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 _____