Ascension

[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. Unfortunately, we are unable to rely on a prior application that is greater than six months old.

Along with the application, you will need to provide verification of your household's income and verification of all assets owned by any household member.

Examples of proof of income and assets include:

- 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
- Copy of receipt of unemployment benefits
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance
- Other income validation documents

Examples of proof of assets include:

- Current bank statements (checking and savings accounts) from last 3 months
- Investments, including stocks and bonds
- Trust funds
- Money market accounts
- Mutual funds

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 do not receive assistance from family and friends, you do not need to fill out the Letter of Support form.

Finally, we may be able to consider your outstanding medical bills to qualify you for financial assistance. If you would like for us to consider this, please also provide documentation of your outstanding monthly medical and pharmacy/drug costs, such as current invoices or statements of account balances. **Please know that the 1) completed application along with 2) proof of income, 3) assets, and 4) outstanding medical bills (if applicable) must be received in order for the application to be considered. We are unable to process or consider applications that are not complete.**

When submitting your application, please keep in mind that communications via email over the internet are not secure. Although it may be 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
Ascension Saint Thomas West	(800)-242-7416	Ascension St. Thomas Financial Assistance Team PO Box 504475 St. Louis, MO 63150-0001	(629)204-6542	
Ascension Saint Thomas Midtown	(800)-242-7416	Ascension St. Thomas Midtown Financial Asst. Team PO Box 504475 St. Louis, MO 63150-0001	(629)204-6540	
Ascension Saint Thomas Rutherford	(800)-242-7416	Ascension St. Thomas Rutherford Financial Asst. Team PO Box 504475 St. Louis, MO 63150-0001	(629)204-6541	
Ascension Medical Group Financial Assistance	(833)263-9791	STHe Financial Asst. PO Box 80278 Indianapolis, IN 46240	(317)981-6312	AscensionFinancialCounselors@r1rcm.com
Ascension Saint Thomas Highlands	(877)348-7082	Ascension St. Thomas Highlands Financial Asst. Team PO Box 504475 St. Louis, MO 63150-0001	(931)738-2669	
Ascension Saint Thomas Dekalb	(877)348-7082	Ascension St. Thomas Dekalb Financial Asst. Team PO Box 504475 St. Louis, MO 63150-0001	(931)738-2669	
Ascension Saint Thomas River Park	(877)348-7082	Ascension St. Thomas River Park Financial Asst. Team PO Box 504475 St. Louis, MO 63150-0001	(931)738-2669	
Ascension Saint Thomas Three Rivers	(931)296-0266	Ascension St. Thomas Three Rivers Financial Asst. Team 451 Hwy 13 S. Waverly, TN 37185	(931)296-4561	
Ascension Saint Thomas Stones River	(877)348-7082	Ascension St. Thomas Stones River Financial Asst. Team PO Box 504475 St. Louis, MO 63150-0001	(931)738-2669	
Ascension Saint Thomas Hickman	(931)729-6800	Ascension St. Thomas Hickman 135 E. Swan Street Centerville, TN 37033	(931)729-0174	
Ascension Saint Thomas Lab Plus	(615)284-2773	Lab Plus LLC Attn: Billing Dept 2000 Church Street Nashville, TN 37236	(615)284-2771	
Ascension Saint Thomas Center for Speciality Surgery	(615)341-7500	STHe Financial Asst. 2011 Murphy Ave, Ste 400 Nashville, TN 37203	(615)341-7513	
Saint Thomas EMS	(877)664-4076	STHe Financial Assistance PO Box 681787 Franklin, TN 37064	(615)236-4040	
Baptist Ambulatory Surgical Center	(615)321-7330	STHe Financial Asst. 312 21st Ave. North Nashville, TN 37203	(615)320-5319	
Ascension Saint Thomas Center for Sleep	(615)222-6638	STHe Financial Asst. PO Box 380 Nashville, TN 37202	(629)204-6544	

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Saint Thomas

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 __ _

Soda! security number (optional) ----------

Employer _____ Employment status _____

Number of hours worked per week Employer phone number _____

Responsible party spouse information

(ff patient is same as responsible part}', 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 doJfar 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 _____

Ihereby 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 tono 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 _____