

Date: _____

Hospital /Clinic: _____

Patient: _____

CPI: _____

Dear Patient/Guarantor,

To best assist you in resolving your account, please complete the attached financial evaluation form. The information you provide is strictly confidential. The completed application should be returned to us promptly with:

- Most recent complete federal tax return, including all schedules.
- Copy of 2 most recent bank statements for all bank accounts.
- Proof of any cash or fluid assets such as stocks, bonds, CDs, Insurance policies, mutual funds, etc.
- Three (3) recent, consecutive employment pay stubs and/or verification of your income (social security benefit, pension, annuity, child support, interest income, unemployment, trust funds, etc.).
- If you have received a Public Assistance Award letter (Food stamps, Medicaid, TANF) please send a copy.
- A copy of a government issued photo ID

A self-addressed, postage paid envelope has been provided for your convenience.

Applications will not be processed or assessed without ALL the appropriate documentation. Incomplete applications will be mailed back to you.

If you have any questions regarding the financial evaluation form, please contact Customer Service at 1-866-611-1514

Thank you,
Customer Service

Answers to commonly asked questions about Financial Assistance

Why do I have to complete this application?

Saint Joseph Health System is a not-for-profit organization. We are required by the federal government to verify certain information for patients that are receiving free or reduced health care services.

What happens to my bill in the mean time?

Simply applying for financial assistance does not stop your bill from going to collections. Your bill will follow the normal collection process until your application is approved. You will still receive statements, letters, and phone calls until you are approved. It is therefore **EXTREMELY IMPORTANT** to complete the application and return it as soon as possible.

What about identity theft? Is the information that I submit protected?

The information that you submit is confidential. It is stored in a secured environment. Only certain employees of Saint Joseph Health System are allowed access to your personal financial information.

Can someone help me with the application process?

Yes, every effort will be made to assist you with this process. We have staff and volunteers available to assist you in completing the application. If you need assistance, please contact our office at the number provided on the cover letter.

Why do I have to have to apply for other programs like HIP or Medicaid?

While anyone can apply for financial assistance, you are required to exhaust all government, and/or private, health coverage programs such as Medicaid, Medicare, Veterans benefits, etc. There may be exceptions to this rule. Please contact our office if you think you may qualify for assistance.

How do I know if I am eligible for other healthcare programs?

The Eligibility Assistance Staff are aware of all the state, local and federal health coverage programs. If you are eligible for any program the staff will notify you and ask you to apply. Assistance in applying for other programs may be available. Contact our office for more information 574.335.8744.

What if I cannot provide all of the financial documentation?

This information is required. If you cannot provide this information, please contact our office for further assistance.

How will I know if I qualify for assistance after I apply?

An approval or denial letter will be mailed to you. If you have not received a call or letter from our office within 45 days, please call our customer service at 1.866.611.1514

What if I have other health care coverage or do not qualify for assistance?

SJHS accepts most insurance plans, Medicaid, Medicare and many other plans as well. We also provide different payment options and plans that help cover health costs. Call our office for more information regarding other payment options or locations that may accept your insurance.

If you have other questions that were not answered please call our office.



Saint Joseph Regional Medical Center
 Saint Joseph Family Medicine Center
 Sister Maura Brannick, CSC Health Center

Mobile Medical Unit
 Saint Joseph Regional Medical Center
 (Plymouth) Saint Joseph Physician Network

CONFIDENTIAL FINANCIAL EVALUATION

PLEASE COMPLETE THIS FORM FULLY AND RETURN - APPLICATION/EVALUATION CANNOT BE PROCESSED OR ASSESSED WITHOUT INCOME VERIFICATION. **IF YOU HAVE NO INCOME, PLEASE PROVIDE EXPLANATION OF HOW YOUR LIVING EXPENSES (HOUSING, FOOD, UTILITIES, ETC.) ARE PAID.** THANK YOU

Account Number _____ Marital Status _____
 Patient Name _____ Date of Birth _____
 Address _____ Telephone _____
 Social Security Number _____

I AM: On Food Stamps Living at a homeless shelter On Emergency Only Medicaid On TANF

If receiving Medicaid, TANF or Food Stamps please provide case # _____

EQUITY IN CARE (Optional) Race: _____ Ethnicity: _____

Preferred Language: English Spanish Other: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR THE INDIVIDUAL RESPONSIBLE FOR PAYMENT

Name _____ Date of Birth _____
 Address (if different) _____ Telephone _____
 Social Security Number _____

PLEASE PROVIDE THE FOLLOWING FOR ALL HOUSEHOLD MEMBERS (Attach additional sheet if necessary)

Name	Date of Birth	Relationship to Patient	Social Security Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have insurance? No Yes Do you have Medicaid? No Yes Do you have Medicare? No Yes
 Are you or someone in your household a veteran? No Yes If yes, Name _____
 Do you or your spouse have 401 (K), 403(b) or other retirement savings? No Yes, If yes type _____
 Anyone receiving SSI/SSDI as a result of a disability ? No Yes if yes, Name _____

HOUSEHOLD INCOME FROM EMPLOYMENT

Person Employed	Employer	Gross Pay	Per
_____	_____	_____	<input type="checkbox"/> WK <input type="checkbox"/> 2 WKs <input type="checkbox"/> Mo
_____	_____	_____	<input type="checkbox"/> WK <input type="checkbox"/> 2 WKs <input type="checkbox"/> Mo
_____	_____	_____	<input type="checkbox"/> WK <input type="checkbox"/> 2 WKs <input type="checkbox"/> Mo

HOUSEHOLD INCOME FROM OTHER SOURCES

	AMOUNT PER MONTH
Child Support / Alimony Received	\$ _____
Food Stamps / Foster Care / Township Trustee / Church	\$ _____
Pension / Social Security / Social Security Disability	\$ _____
Rental Property.....	\$ _____
Stocks, Bonds, Annuities, Interest.....	\$ _____
Unemployment or Worker's Compensation	\$ _____
TOTAL MONTHLY INCOME?	\$ _____

Continues on other side

ASSETS

Cash on Hand		\$	_____
Checking Account	Bank _____	\$	_____
Health/Medical Savings Account.....		\$	_____
401(K), 403(b) or Other Retirement Savings		\$	_____
Investments or Other Securities.....		\$	_____
Life Insurance Policy Cash Value.....		\$	_____
Savings Account Balance.....	Bank _____	\$	_____
Stocks, Bonds, IRA, Certificates of Deposit Type/Bank _____		\$	_____
Real Estate (Primary Residence)	Value →	\$	_____
Other Real Estate: Location _____	Value →	\$	_____
Vehicles: Year/Make/Model _____	Value →	\$	_____
..... Year/Make/Model _____	Value →	\$	_____
TOTAL ASSETS		\$	_____

HOUSEHOLD LIABILITIES/EXPENSES

Rent/Mortgage per Month	(Mortgage Balance \$ _____)	\$	_____
Child Care / Child Support / Alimony Paid per Month.....		\$	_____
Utilities per Month: Gas \$ _____	Electric \$ _____	Water/Sewer \$ _____	\$ _____
Telephone	Cell \$ _____	Home \$ _____	\$ _____
Medication Expenses per Month		\$	_____
Medical Needs per Month (including charges, monthly obligations to doctors or other hospitals)		\$	_____
Insurance Premiums per Month: Life \$ _____	Auto \$ _____	Home \$ _____	Health \$ _____
TOTAL MONTHLY PAYMENTS		\$	_____

- Please attach a note describing other conditions that you feel have created a hardship such as, illness, increased medical expenses, unemployment, etc.
- Please refer to verification page of documents required for consideration.

I certify that all information is true and complete to the best of my knowledge. I understand that the information provided will be verified and treated as personal and confidential. I authorize Saint Joseph Health System (SJHS) and/or it's affiliates to obtain a credit report, banking information and employment information. I authorize the release of any and all in- formation from the Indiana Division of Family and Children Services. I understand that I must provide verification of income, expenses, dependents, bank statements, pay vouchers and tax statements. I consent to the release financial information, including the information on this form, which may include federal tax returns, bank statements, check stubs, or other relevant financial information obtained by SJHS for the purposes of determining eligibility under the Pharmaceutical Patient Assistance Program (PAP). I consent to have the PAP and/or its agents audit or otherwise verify the information I have provided on this form to determine my eligibility for any PAP. I understand my responsibility to notify SJHS/PAP if my financial situation changes or if I obtain medical insurance. I also understand that I will be liable for full payment of any services rendered at any Saint Joseph Health System affiliate if the above information is given under false pretenses or if I fail to inform them of any changes.

Signature: _____ Date: _____ Time: _____
 Witness: _____ Date: _____ Time: _____

OFFICE USE ONLY

Approved for financial assistance Yes No What % _____ Renewal Date Denial _____
 Reason: _____