Saint Agnes Medical Center

Financial Assistance Application

Saint Agnes Medical Center has financial assistance available to all patients who qualify. Please understand that if you qualify for financial assistance it does not mean all accounts or future accounts will qualify for the same assistance. All financial resources such as: personal insurance, Medicare, Medi-Cal, County Assistance, etc. must be exhausted before financial assistance will be considered.

Saint Agnes Medical Center has applications available for the following programs: Medi-Cal, Healthy Families, California Children's Services, or information on applying for Medicare eligibility. Please contact out Financial Counselor at **(559) 450-5247 for additional information.**

If you and/or a family member have applied for financial assistance at Saint Agnes within the last six months, please call us 1-855-224-5998 before completing this application.

Saint Agnes will need the following documents to review and complete the application process. If this information is not attached the financial assistance application may be denied.

- Three (3) months bank statements. **(Required)**
- The 3 most recent pay stubs for yourself and/or your spouse.
- A W2 or federal tax return for you and/or your spouse.
- Social security and/or social security disability for you and/or your spouse-
  - Award letter (copy), Check (copy), Bank statement-showing automatic deposit
- If self-employed, the most recent federal tax return and all schedules to include profit and loss statements.
- Unemployment statements.
- A letter from Social Security Disabilities stating a claim is being reviewed, denied or pending.
- Any other documentation showing income.
- A letter from family or friends if you are receiving financial help with monthly expenses, such as rent, utilities, etc.
- Food stamp documentation.
- A letter from a halfway house, shelter, or Vocational Rehab, if applicable.

Thank you for your cooperation in this important matter.

Please return the financial assistance application and proof-of-income to:

Patient Accounts
PO Box 190930
Boise ID 83719-9919

Return by _____

Please allow approximately 30-45 days for the application to be processed. If you have any questions, please feel free to contact our **Customer Service Department at 1-855-224-5998.**

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CONFIDENTIAL FINANCIAL EVALUATION

Saint Agnes has financial assistance available to all patients who qualify. Please understand that if you qualify for financial assistance it does not mean all accounts or future accounts will qualify for the same assistance. All financial resources such as: personal insurance, Medicare, Medi-Cal, County Assistance, etc. must be exhausted before financial assistance will be considered.

Do you have Insurance? No __ Yes__ Do you have Medicare? No __ Yes __
Do you have Medi-Cal? No __ Yes__
(If so, attach a copy of your insurance card to this application.)

Have you applied for Financial Assistance at Saint Agnes within the last 6 Months? No __ Yes __

Patient Name: _____Account #: _____Account Balance_____

Date of Birth: _____ Social Security Number: _____ E-mail: _____

Address: _____City:_____ST:_____Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Individual's information responsible for payment:

Name: _____ Date of Birth: _____ Social Security #:_____

Address (if Different) _____ Telephone: _____

_____ Social Security Number: _____

Please provide the following for all additional household members (Attach Additional sheet if necessary)

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

HOUSEHOLD INCOME FROM EMPLOYERS

Person Employed	Employer	Hourly Wage	Hours/Week	Monthly Total
_____	_____	$_____	_____	$_____
_____	_____	$_____	_____	$_____
_____	_____	$_____	_____	$_____

Are you a student? (Y / N)...If yes, does the school require you to carry health insurance? (Y / N)

Name of School _____ **(Please attach copy of school schedule)**

Saint Agnes Medical Center

HOUSEHOLD INCOME FROM OTHER SOURCES

Child Support / Alimony

Received……$_____

Food Stamps / Foster Care……$_____

Pension / Social Security / Social Security Disability……. $_____

Rental Property (Address :_____) $_____

Stocks, Bonds, Annuities, Interest…… $_____

Unemployment or Worker's Compensation…….. $_____

Other Income (From family, friends, church, etc.)……. $_____

TOTAL MONTHLY INCOME **$_____**

ASSETS	**TOTAL:**
Checking Account Balance: _____ Savings Account Balance: _____	$_____
Health/Medical Savings Account……..…….	$_____
Investments or Other Securities…..……	$_____
Life Insurance Policy Cash Value……..……..	$_____
Stocks, Bonds, Certificates of Deposit Type/Bank_____	$_____
Real Estate (Primary Residence)…… …… …… Value →	$_____
Other Real Estate……Location_____ Value →	$_____
TOTAL ASSETS →	**$_____**

MONTHLY HOUSEHOLD LIABILITIES/EXPENSES	**Balances**	**Monthly Payment**
Rent/Mortgage per Month…….	$_____	$_____
Car Loan Payments Per Month……..…	$_____	$_____
Loan/Student Loan Payments Per Month…….	$_____	$_____
Credit Card Payments per Month…….	$_____	$_____
Utilities (Power, Gas, Water, Sewer, Trash) ……		$_____
Cable/Internet……. .		$_____
Phone/Cell Phone ……		$_____
Daycare and/or Child Support…….. .		$_____
Grocery Expense…….. ..		$_____
Vehicle Insurance ……..		$_____

Fuel..... $_____

Health Insurance ..... $_____

Medication Expenses per Month..... $_____

Any other monthly expenses ..... $_____

Total Medical obligations to other providers ..... $_____

TOTAL MONTHLY PAYMENTS **$**_____

OTHER INFORMATION WE SHOULD KNOW TO ASSIST IN OUR UNDERSTANDING OF YOUR FINANCIAL SITUATION. IF YOU HAVE NO MONTHLY INCOME, PLEASE TELL US ABOUT YOUR SITUATION:

_____

_____

If we need additional information, you will be notified by telephone, US Mail or e-mail.

- 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 Agnes Medical Center to obtain a credit report and to verify banking information and employment information.
- **I understand that I must provide verification of income, expenses, dependents, bank statements, pay vouchers and tax statements if applicable.**
- I also understand that I will be liable for full payment of any services rendered at Saint Agnes Medical Center if the above information is given under false pretenses.
- I know that I am asking for financial assistance from Saint Agnes Medical Center only and not from other health care providers or physicians.

Signature_____ Date_____

For Hospital Use Only:

Application Received: _____

Application Expires: _____

Charity % Approved: _____

Charity % Requested: _____

Extra Information requested: _____

Need by: _____

Information Received: _____