

## FINANCIAL ASSISTANCE APPLICATION REQUIRED DOCUMENTS

Patients applying for Financial Assistance MUST provide the following:

#### All sources of income for your household including:

- Paystub/s (most recent 2 paystubs)
- Bank Statements (last 2 months)
- Tax Information:
  - o Tax Returns (most recent)
  - o W2's
  - o Social Security Income Benefit Statement

### If applicable:

- VA Benefits
- Medicaid Award Letters
- For Patients who have **Medicare**:
   Enclose a copy of your bills
- o For "Self-Employed" Patients:
  - Include a copy of last year's Federal Tax Return and/or an Income/Expense Report showing at least the last 4-6 months of activity

#### **MEDICAID:**

Patients applying for **Medicaid** NEED to provide the following:

### **Proof of Identification such as:**

- Driver's License
- Birth Certificate

### All types of income, earned and unearned including:

- Paystubs (most recent 2 paystubs)
- Retirement Benefits
- Social Security Statements
- Income Tax Returns

#### **Proof of resources:**

- Bank Statements (last 2 months)
- Insurance Policies
- Property Property Tax Bill or copy of Deed

#### **Proof or Residence:**

- Rent Receipt
- Landlord Statement
- Deed
- Car Registration



# **Financial Assistance Application**

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ate of Birth	:	S	ocial Security:		
pous	se Inform	ation			
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Household Information Are you in school?  Are you in school?  Do You have Health Insurance?  Y N  Do you have Medicare  Y N  Do you have Medicaid?  Y N  Do you have Medicaid?  Y N  Employment and Insurance Information  Employer  Applicant:  Co-Applicant:  Co-Applicant:  Co-Applicant:  Other Wages:  S  I.e. Child support, Tips, Rental Income, Veterans benefits, Trust, SSI/Disability  ACKNOWledgement  Ihereby acknowledge that the information in this application (including any attachments) is true, complete and accurate to the best of my knowledge. Furthermore, I understand that to qualify for Financial Assistance, I must take all steps necessary to apply for and obtain any other available payment sources (such as Medicaid, Medicare, insurance, etc.).  Ihereby authorize St. Joseph Regional Medical Center to contact any person, firm or organization to verify any of the information given, and I hereby authorize any such person, firm or organization to release such information to St. Joseph Regional medical Center (see attached for facility address). I also authorize St. Joseph Regional medical Center to request a consumer credit report.  Date  Co-Applicant Signature:  Date							
Do You have Health Insurance?  Is insurance offered by school or work?  Y N  Do you have Medicare  Do you have Medicaid?  Y N  Do you receive veterans benefits?  Y N  Employment and Insurance Information  Employer  Applicant:  Co-Applicant:  Co-Applicant:  Co-Applicant:  Co-Mapplicant:  Comment:  Other Wages:  \$   Applicant/Co-Applicant    Comment:  Other Wages:    Solution   Soluti		ition					
Is insurance offered by school or work? Y N Do you have Medicare Y N Do you have Medicare Y N Do you have Medicare Y N Do you receive veterans benefits? Y N    Semployment and Insurance Information   Employer	Are you in school?		Υ	N			
Do you have Medicaid?  Do you receive veterans benefits?  Financial Assistance, I must take all steps necessary to apply for and obtain any other available payment sources (such as Medicaid, Medicare, insurance, etc.).  I hereby authorize St. Joseph Regional Medical Center to contact any person, firm or organization to release such information to St. Joseph Regional medical Center to request a consumer credit report.  Applicant Signature:  Date  Comment:    V			Υ	N			
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Co-Applicant Signature:	Applicant Signature	:: 					
						Date	
	Co-Applicant Signat	cure:				Data	

\*We will not be able to process a charity application without all of the necessary documents.\*
e.g. 2 bank statements, 2 pay stubs, tax returns, other income received (e.g. child support, social security, alimony), If you have no income, provide a letter or a comment below from you stating your source for paying living expenses. Please allow 30 days for processing

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Processed By:	Financial Counselor	Date:						
Eligibility Determination:	( ) Yes ( ) No Discount:		%					
Justification:								
Reviewed/Approved By:								
Reviewed/Approved by.	Financial Services Director	Date						
	Hospital Controller/CFO	Date						

\*