St. David's Healthcare Partnership Financial Assistance Application

Patient Name _____ Patient Account Number _____

Telephone Number _____ Social Security Number _____ Birth Date (Month/Day/Year) _____

☐ Employed
☐ Unemployed

Employer (Name, Address and Telephone Number) _____

Spouse Name _____ Social Security Number _____ Birth Date (Month/Day/Year) _____

Patient's Father (If patient is a minor) _____ Social Security Number _____ Birth Date (Month/Day/Year) _____

Patient's Mother (If patient is a minor) _____ Social Security Number _____ Birth Date (Month/Day/Year) _____

A. ***Wages:*** Please provide the wages for each of the following persons in your household.

		Circle One						Circle One
Patient	$_____	Hr/ ☐	Wk/ ☐	Month/ ☐	Year ☐	Patient's Father (if patient is a minor)	$_____	Hr/ ☐ Wk/ ☐ Month/ ☐ Year ☐
Spouse	$_____	Hr/ ☐	Wk/ ☐	Month/ ☐	Year ☐	Patient's Mother (if patient is a minor)	$_____	Hr/ ☐ Wk/ ☐ Month/ ☐ Year ☐

B. ***Other Resources:*** Please provide the total amount of other resources available to you, including savings accounts, checking accounts, stocks, bonds, etc. $ _____

Please provide the amount of yearly income you receive from these other resources, including interest income, dividends, rental income, etc. $ _____

C. ***Family Members:*** Please provide the number of persons in the patient's household. _____

D. ***Income Verification:*** Please provide any of the following types of documentation to verify your income.

- IRS Form W-2
- Paycheck Remittance
- Tax Return
- Bank Statements
- Employer Verification
- Proof of Participation in Governmental Assistance programs such as food stamps, CDIC, Medicaid or AFDC
- Social Security or Unemployment Compensation Determination Letters
- Other, Please Describe

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

_____

I understand St. David's Healthcare Partnership (SDHP) may verify the financial information contained in this Financial Assistance Application ("Application") in connection with SDHP' evaluation of this Application, and by my signature hereby authorize my employer to certify the information provided in this Application. I also authorize SDHP to request reports from credit reporting agencies and the Social Security Administration. I certify that this information is true to the best of my knowledge and I am aware that falsification of information on this Application may result in denial of financial assistance.

I understand that any financial assistance is based on my inability to pay and that if any new source of income becomes available SDHP may reverse its grant of financial assistance in whole or in part.

_____ Date _____
Signature of Patient or Responsible Party

_____ Date _____
SDHP Employee Signature if any part of Financial
Assistance Application Completed by an SDHP Employee

St. David's Healthcare Partnership Financial Assistance Application Information and Instructions

***Instructions*:**

As part of its commitment to serve the community and in fulfilling one of the charitable purposes of St. David's Healthcare System, St. David's Healthcare Partnership elects to provide financial assistance to individuals who satisfy certain income requirements.

To determine if a person may qualify for financial assistance, we need to obtain certain financial information as outlined within this application. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Please complete the Financial Assistance Application and return the completed form to the Registration Representative; or the completed form may be mailed to the following address:

Patient Account Services
PO Box 292369
Nashville, TN 37229-2369

Section A: Wages

In Section A of the Financial Assistance Application, please indicate the Dollar Amount each listed person receives as compensation and whether the amount represents hourly, weekly, monthly, or yearly compensation.

Section B: Other Resources

In the first blank in Section B of the Financial Assistance Application, please indicate the Dollar Amount you have invested in checking accounts, savings accounts, stocks, etc. In the second blank please indicate the Dollar Amount of income you receive yearly from such investments. For example, in the first blank one might put that they have $5,000 in a savings account and in the second blank they might put that they earn $250 interest yearly on that account.

Section C: Family Members

Section C of the Financial Assistance Application requests information on the number of persons in the patient's household. This number should include the patient, the patient's spouse and the patient's dependents. If the patient is a minor, please include the patient, the patient's mother and/or father and/or legal guardian and any Resident Dependents of the patient's mother and/or father, and/or Legal Guardian.

Section D: Income Verification

In order to consider your request for financial assistance, verification of the wages reported in Section A of the Financial Assistance Application is required. Please provide a copy of an IRS Form W-2, Wages and Tax Statement; pay check remittance; tax return; bank statement or other appropriate indicator of income ***or*** proof of participation in a public benefit program such as Social Security, Unemployment Compensation, Medicaid, County Indigent Health Program, AFDC, Unemployment Insurance, Food Stamps, WIC, Texas Healthy Kids, Children's Health Insurance Program, or other similar indigency related programs.

You may also verify your wages by having your employer provide written verification or by having your employer speak with an SDHP representative.

If you are unable to provide one of the sources of income documentation listed above, please provide a written explanation in Section D of the Financial Assistance Application.

Physician Services

The physicians providing services are not employees of St. David's Healthcare Partnership. You will receive separate bills from your private physician and from other physicians whose services you required. For questions regarding these bills, or to make payment arrangements for physician services, please contact the individual physician's office.