CHI Saint Joseph Health

Financial Assistance Application (FAA)

Patient Demographics

Patient Name: Last, First, Middle	**Social Security # (If available)**	**Date of Birth**	**Account #** **Location of Service**
Guarantor Name: Last, First, Middle	**Social Security # (If available)**	**Date of Birth**	**Relationship to Patient**
Patient/ Guarantor Address	**County of Residence**	**Home Phone #**	**Alternate Phone #**
City	**State**	**Zip Code**	**Homeowner? Yes No**
Have you applied for Medicaid or any other State/County Assistance? (Circle one) Yes No **If Yes, Please provide the following:**			
Application Date:		**Status of Application:**	
Caseworker Name:		**Caseworker Phone Number:**	

Household Information

Marital Status:	**Married**	**Single**	**Separated**	**Divorced**	**Widowed**

Dependent Names	**Relationship**	**Date of Birth**

Employment/Household Income and Expenses

Patient/Guarantor Employer Name	**Gross Monthly Income: $**	**Provide verification**
If income is $0, please explain.		**Provide documentation**
Spouse's Employer Name	**Gross Monthly Income: $**	**Provide verification**
If income is $0, please explain.		**Provide documentation**
Other Income Source:	**Gross Monthly Income: $**	**Provide verification**
EXPENSES ARE NOT REQURIED FOR NHSC APPLICATIONS		
Household Monthly Expenses	**Total Monthly Expenses: $**	

IMPORTANT: To qualify for assistance, at least one piece of supporting documentation that verifies household income may be required. Supporting documentation can include but is not limited to, most recent year's tax return, a current W-2, 1 month of current pay-stubs, signed letter of support, etc.

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PLEASE READ THE FOLLOWING BEFORE SIGNING AND DATING THE APPLICATION

Please be advised that your signature indicates you have agreed to attach income verification.

- I certify that the information I have provided is true and accurate to the best of my knowledge.
- I will independently or with the assistance of hospital personnel apply for ANY and ALL Assistance which may be available through federal, state, local government and private sources to help pay this healthcare bill.
- I understand that if I do not cooperate with my healthcare provider in providing requested information, my application may be denied for possible financial assistance.
- I understand that the information which I submit is subject to verification by my healthcare provider, including credit reporting agencies and subject to review by Federal and/or State agencies and others as required.
- I understand that additional information may be requested in order to qualify for assistance.

Signature (Applicant/Guarantor)	**Date**

Return To:

Financial Assistance Center
PO Box 650953
Dallas, TX 75265-0953

Phone: (855) 715-4379

Email: *CHIFA@coniferhealth.com*