CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE

For Hospital and Professional services provided by facilities and physicians of Trinity Health

Trinity Health

ST. JOSEPH'S HEALTH
A Member of Trinity Health

Personal & Confidential

Guarantor: _____

Date: _____

Guarantor:
Case Number:
Patients Included in Case:

Dear *Guarantor Name*,

Thank you for selecting St. Peter's Health Partners as your health care provider. Please complete the enclosed application and return to the address below to complete the evaluation of your financial assistance.
If you have any questions, please contact our Customer Service Center at 800-494-5797 Monday through Friday between 9:00 am - 5:00 pm EST.

Sincerely,

Trinity Health Enterprise Patient Financial Services
On behalf of St. Peter's Health Partners
20555 Victor Parkway
Livonia, MI 48152

Please mail your application to the address above, Fax at 312-871-3350 and or upload documents through MyChart (Patient Portal) - https://mychart.trinity-health.org/MyChart If you have any questions, please contact our Customer Service Center at 855-652-1386, option 2, Monday through Friday 9 AM-5 PM EST.

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Please complete and sign application form and return within 10 days including copies of the following:

Required Verifications

☐ Past One month Proof of Gross Income

☐ Past Two months Complete Bank Statements for all bank accounts, with all pages included (explanation for recurring deposits)

☐ Recent Tax Returns (1040 form with Schedule C, E or F) or Three Months Profit and Loss Statements (for self-employed/dependents)

Provide the following, If applicable

☐ Recent W2 for Seasonal Income ☐ Unemployment Benefit/ Denial letter ☐ Child Support Income/Alimony

☐ No Income – Complete Letter of Financial Support portion of the application

Patient Information

Patient Name		Date of Birth	
Social Security/EIN Number (optional)	Mobile Phone	Other Phone	
Mailing Address	City	State	Zip code
Email Address	What state are you a resident of?		
Marital status Single □ Married □ Divorced □ Other □ _____			
Do you file a Federal Tax Return? □ Yes □ No If no, why?	Can you be claimed as dependent on someone else's tax return? □ Yes □ No		
Did you or your dependents have health insurance coverage at the time of service? □ Yes □ No (Provide Insurance card copy)			
Are you a documented resident of the United States? □ Yes □ No □ Prefer Not to Answer			

Household Members, including yourself based on your recent Tax Returns	Date of Birth	Relationship to Patient	Claimed on Tax Return (Y/N)

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Income Verification for all household members					
Monthly Income Source	Who receives this?	Gross Monthly Income (before taxes)	Monthly Income Source	Who receives this?	Gross Monthly Income (before taxes)
Wages			Worker's Compensation		
Social Security/Disability			Unemployment		
Pension			Child Support/Alimony		
Self-Employment			Rental Land Income		
Public Assistance			Other		

Letter of Financial Support - Should only be completed by support provider

☐ I provide more than 50% support for the patient's living expenses, but I am unable to help with medical bills.

☐ By signing this letter, I verify that the above statement is correct and that I will in no way be held liable for the patient's bills. If you have questions, please contact me at _____ (Phone Number)

Name of person supporting	**Relationship to Patient**
Signature of person providing support	**Date**

VERIFICATION OF INCOME AND IDENTIFICATION

I certify that the information listed in this application is true and complete to the best of my knowledge. I understand that the information provided is subject to verification. I will be responsible for repayment of any services provided at Trinity Health affiliates if the above information is provided under false pretenses.

Signature of Patient: _____Date: _____

Or Signature of Legal Guardian: _____Date: _____
(If Applicable)
Relationship to Patient: _____ Date: _____

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