

**[CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE]**

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

Personal & Confidential

Thank you for selecting *Saint Alphonsus* 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 a.m. - 5:00 p.m. ET.

Sincerely,

Trinity Health Enterprise Patient Financial Services

On behalf of *Saint Alphonsus*

20555 Victor Parkway

Livonia, MI 48152

**[CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE]**

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

**[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]	[Of what state are you a resident?]		
[Marital status] <input type="checkbox"/> [Single] <input type="checkbox"/> [Married] <input type="checkbox"/> [Divorced] <input type="checkbox"/> [Other] _____			
[Do you file a Federal Tax Return?] <input type="checkbox"/> [Yes] <input type="checkbox"/> [No] [If no, why?]		[Can you be claimed as dependent on someone else's tax return?] <input type="checkbox"/> [Yes] <input type="checkbox"/> [No]	
[Did you or your dependents have health insurance coverage at the time of service? <input type="checkbox"/> [Yes] <input type="checkbox"/> [No] [(Provide Insurance card copy)			
[Are you a documented resident of the United States? <input type="checkbox"/> [Yes] <input type="checkbox"/> [No] <input type="checkbox"/> [Prefer Not to Answer]			

[Household Members, including yourself based on your recent Tax Returns]	[Date of Birth]	[Relationship to Patient]	[Claimed on Tax Return (Yes/No)]

**[CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE]**

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

<b>[Income Verification for all household members]</b>					
[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]		
<b>[Letter of Financial Support - Should only be completed by the person providing support]</b>					
<input type="checkbox"/> [I provide more than 50% support for the patient's living expenses, but I am unable to help with medical bills.]					
<input type="checkbox"/> [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)]					
<b>[Name of person providing support]</b>				<b>[Relationship to Patient]</b>	
<b>[Signature of person providing support]</b>				<b>[Date]</b>	

**[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.]

**[CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE]**

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

[Signature of Patient]: \_\_\_\_\_ [Date]: \_\_\_\_\_

[Or Signature of Legal Guardian (If Applicable)]: \_\_\_\_\_ [Date]: \_\_\_\_\_

[Relationship to Patient]: \_\_\_\_\_ [Date]: \_\_\_\_\_

**[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 800-494-5797 Monday through Friday 9 a.m. -5 p.m. ET. ]**