Saint Alphonsus

Thank you for your interest in our Financial Assistance Program. If you and/or a family member have applied for financial assistance at Saint Alphonsus within the last six (6) months, please contact our office at (208) 367-2130 or (866) 626-7272 before completing this application.

Please return the completed application and all applicable documents listed below within thirty (30) days:

- **Three (3) months complete, itemized bank statements for all checking, savings, and/or investment accounts showing deposits and withdrawals. Please provide explanation for all deposits. (Required)**

- **Proof of earned and/or unearned income as documented below. (Required)**
  1. Three (3) recent pay stubs for yourself, spouse and all dependents showing pay rate and hours worked OR
  2. Current, or most recently filed, federal tax return for yourself and spouse OR
  3. Contribution statement from family/friends stating how living expenses are being met
     AND
  4. Any of the following documents, as applicable for yourself, spouse and all dependents:
     ○ Most recent tax return including Profit/Loss statement if self-employed ○ Most recent tax return for verification of dependents
     ○ Unemployment benefits statement ○ Student financial aid award letter ○ Determination letter for public assistance (e.g., food stamps, Medicaid, etc.) ○ Social Security and/or Social Security Disability award letter or check ○ Dividend, interest and income from any other source (e.g., rental income, alimony income, retirement benefits, etc.).

If you are unable to provide any of these documents, please provide a letter of explanation as to why the documents were not returned.

Please return the financial assistance application and supporting documents to:

Saint Alphonsus
Patient Financial Services
PO Box 190930
Boise, ID 83719-9919

Return by: _____

Please allow approximately 30 days for processing once we have received a completed application. If you have any questions or require information in another language, please contact our office at the number listed below.

Sincerely,

Saint Alphonsus
Customer Service
(208) 367-2130 or (866) 626-7272

Saint Alphonsus

CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE

Professional services provided by affiliated physicians or other providers may be billed separately. Application of Financial Assistance is at the discretion of those providers in accordance with their policies, procedures, and applicable regulations. The information provided in this application may be provided to affiliated providers to assist the patient. Saint Alphonsus honors the sacredness and dignity of every person, complies with applicable federal and state laws, and does not discriminate on the basis of whether payment for services would be made under Medicare, Medicaid, or CHIP; and the individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity.

Patient Name			Date of Birth
Street Address		Telephone	Message Phone
City/State/Zip			Social Security Number (optional)
Mailing Address (if different) or email if preferred			

Please provide the following information for yourself (if not the patient), spouse and dependents:

Name	SSN (Optional)	Date of Birth	Relationship to Patient

Please list all account numbers and/or dates of service to be considered for financial assistance:

Patient Name	Account #	Date of Service	Medical Balance

Healthcare Marketplace Information

Have you applied for Insurance?	□ No	□ Yes	If Yes, Name/ID
If Yes, did you apply through:			□ Medicaid - State □ Health Exchange/ Healthcare.gov □ Other _____
Were you approved for an insurance plan?	□ No	□ Yes	
Have you enrolled and paid the premium for an insurance plan?	□ No	□ Yes	

Banking Information

Checking Account Balance	Bank:	$
Savings Account Balance	Bank:	$

Employment

Person Employed	Employer	Gross Pay Period	# of Pay Periods	Annual Gross
		$		**$**
		$		**$**
		$		**$**
		$		**$**

Other income Source	**Monthly**	**Annually**
Alimony	$	$
Public Assistance Program Type _____ (e.g., Cash, Food Stamps, etc.)	$	$
Payment from Retirement Plan	$	$
Social Security / Social Security Disability	$	$
Unemployment or Worker's Comp No. of Weeks:_____ (Start Date:_____ End Date: _____) Per Week $:_____	$	$
Other Income (Stocks/Bonds/Annuities/Interest/Rental Property)	$	$
Other Income (from family, friends, church, etc…)	$	$

VERIFICATION OF INCOME AND IDENTIFICATION

If we need additional information, you will be notified by telephone, US Mail or e-mail.

I certify that all information is true and complete to the best of my knowledge. I understand that the information provided will be verified and treated as personal and confidential. I authorize the release of any and all information from the Idaho Division of Family and Children's Services or the Oregon Department of Human Services. **I understand that I must provide verification of income, dependents, bank statements, pay vouchers and tax statements if applicable.** I also understand that I will be liable for payment of any services rendered at Saint Alphonsus if the above information is given under false pretenses. I know that I am asking for financial assistance from Saint Alphonsus only and not from other health care providers or physicians.

SIGNATURE: **DATE:**

_____ _____

SPOUSE SIGNATURE (if applicable): **DATE:**

_____ _____

Non-Discrimination Notice

Saint Alphonsus Health System, Inc. honors the sacredness and dignity of every person, complies with applicable Federal civil rights laws, and does not discriminate on the basis of protected classes, including but not limited to age, race, skin color, national origin (including ethnicity, culture, or language), religion, physical or mental disability, socioeconomic status, or sex (including sexual orientation, gender identity, or gender expression).

Saint Alphonsus Health System, Inc.:

- **Provides free aids and services to people with disabilities to communicate effectively with us, such as:**
- Qualified sign language interpreters
- Written information in other formats such as large print, audio, accessible electronic and other formats
- **Provides free language services to people whose primary language is not English, such as:**
- Qualified interpreters
- Information written in other languages

If you need these services, contact our Community Services Coordinator at 1-866-727-6248.

If you believe that Saint Alphonsus Health System, Inc. has failed to provide these services or discriminated in another way on the basis of age, race, skin color, national origin (including ethnicity, culture, or language), religion, physical or mental disability, socioeconomic status, or sex (including sexual orientation, gender identity, or gender expression), you can file a grievance in person, by mail, fax or email to:

- Patient Relations Coordinator
  1055 N Curtis Road, Boise, Idaho 83706
- Phone: 208-367-6226 I Fax: 208-367-8181
- Email: BO-PatientRelations@saintalphonsus.org

If you need help filing a grievance the Patient Relations Coordinator is available to help you. You can also file a civil rights complaint with the US Department of Health & Human Services, Office for Civil Rights electronically via web, by mail or phone to:

- US Department of Health & Human Service 200 Independence Avenue, SW,
  Room 509F, HHH Building, Washington, DC 20201
- Web: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Phone: 1-800-368-1019 I TTY 1-800-537-7697

Saint Alphonsus
A Member of Trinity Health

Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات الترجمة اللغوية تتوافر لك بالمجان.
اتصل بالرقم: 1-866-727-6248 , (رقم هاتف الصم والبكم:1-844-801-7932)

Burmese

သတိ။ ။ သင် [ဗမာစကား] ပြောရင် ဘာသာစကားအတွက် အကူအညီပေးတဲ့ဝန်ဆောင်မှု အခမဲ့ရနိုင်ပါတယ်။ 1-866-727-6248 TTY: 1-844-801-7932 ကို ဖုန်းဆက်ပါ။

Chinese

注意：如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-866-727-6248 TTY：1-844-801-7932。

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-727-6248 تماس بگیرید. 1-844-801-7932 (TTY: 1-844-801-7932).

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-727-6248 ATS : 1-844-801-7932.

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-727-6248 TTY: 1-844-801-7932 まで、お電話にてご連絡ください。

Karen

တ်သူဉ်တ်သး: မ့မ့်နတဲတၢ်ပှၤကညီကျိာ်အကိးလီတဲစိနိဉ်ဂ်ၢ် 1-866-727-6248 TTY: 1-844-801-7932. မၤစၢၤနၢ်သ့ဒီးစ့တလိဉ်ဘဉ်မ့အကလီ. 8426-727-668-1

Kirundi

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-866-727-6248 TTY: 1-844-801-7932.

Korean

안내: [한국어] 를 사용하시는 경우 언어 지원 서비스를 무료 이용하실수 있습니다. 1-866-727-6248 (TTY : 1-844-801-7932) 로 전화해 주십시요.

Nepali

ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नमि्त भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-866-727-6248 दटिविाइ: 1-844-801-7932 ।

Pashtu

خدمات مرستې وړيا ژبې د ،کوی خبرې ژبه پښتو په تاسو که :پاملرنه ونیسی اړیکه شمیری دی په .دي چمتو ته تاسو

Romanian

Atentie: Daca vorbesti [Romania], serviciul de asistanta lingvistic, fara plata, este la indemana ta (disponibil). Suna la Telefonul acesta 1-866-727-6248 sau 1-844-801-7932

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-727-6248 телетайп: 1-844-801-7932.

Serbo-Croatian

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-866-727-6248 TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-844-801-7932.

Somali

DIGNIIN: Haddii aad ku hadasho [luqadda ku dar], adeegyada ka caawinta luqadda, oo lacag la'aan ah ayaa laguu heli karaa. Wac 1-866-727-6248 (TTY: 1-844-801-7932).

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-727-6248 TTY: 1-844-801-7932.

Swahili

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-866-727-6248 TTY: 1-844-801-7932.

Urdu

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-866-727-6248 کریں 1-844-801-7932

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-727-6248 TTY: 1-844-801-7932.

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