Dear Patient/Guarantor:

Thank you for choosing St. Vincent's Health System for your healthcare needs. It is our mission and privilege to offer financial assistance to our patients.

At your request we have provided the attached financial assistance application. In order for us to evaluate your financial situation, the following documents are required:

- ☐ A completed Financial Assistance Application (enclosed);
- ☐ A copy of your most current Federal tax form(s) with ALL schedules, including W-2(s);
- ☐ A copy of your most recent three (3) paycheck stubs for you and anyone working within your household;
- ☐ A copy of your most recent three (3) bank statements for each account that you have;
- ☐ A list of your outstanding medical debts and monthly pharmacy costs; and the name and telephone number for your Medicaid caseworker, if applicable.
- ☐ Other: _____

Incomplete applications will not be processed for assistance. The completed application, including all documentation must be received for consideration.

You may mail your completed application and required documentation to:
St Vincent's Health System
Business Office
810 St. Vincent's Dr.
Birmingham, AL 35205

OR you may fax your completed application and required documentation to:

(317) 583-2753 Attn: NRSC Financial Assistance Representative

If you have any questions please contact our Customer Service Center at 800-566-5050 Monday through Friday 8:00 AM – 1:45 PM & 2:30 PM – 4:00 PM EST.

Sincerely,

National Revenue Service Center
St. Vincent's Health System

St.Vincent's HEALTH SYSTEM
stvhs.com

St. Vincent's Health System

FINANCIAL ASSISTANCE APPLICATION

Please complete the application to the best of your ability, and as fully as possible. This will help us answer your request as quickly as possible. If you would like to provide additional information of any kind that you feel will help us better understand your situation, please attach a letter to this application

You must also provide proof of gross income. This may be in the form of your last three (3) pay stubs, last year's tax return, or other records documenting your year to date income.

PATIENT INFORMATION (PLEASE PRINT) **Account No.**

Patient Name:	**Birth Date**	**Marital Status**	**Sex**		**Telephone No.**
Address:	**City**	**State**	**Zip**		**Email Address**
Social Security Number:	**Employer**		Full Time Part Time		How many hrs/wk
Employer Address:	**City**	**State**	**Zip**		**Telephone No.**

RESPONSIBLE PARTY OTHER THEN PATIENT

Name	**Birth Date**	**Marital Status**	**Sex**		**Telephone No.**
Address		**State**	**Zip**		**Email Address**
Social Security Number	**Employer**		Full Time Part Time		How many hrs/wk
Employer Address	**City**	**State**	**Zip**		**Telephone No.**

SPOUSE'S INFORMATION

Spouse's Name		**Social Security Number**		**Birth Date**
Spouse's Employer:	**Address:**	**City**	**State** **Zip**	**Telephone No.**

DEPENDENTS:

Name	Age	Relationship	Name	Age	Relationship

GROSS MONTHLY INCOME		MONTHLY LIVING EXPENSES	Payment	Balance
Applicant Earned Income		Mortgage/Rent		
Applicant Spouse's Income		Electricity		
Social Security Benefits		Gas		
Pension/Retirement Income		Telephone		
Unemployment Compensation		Water		
Worker's Compensation		Groceries		
Interest / Dividend Income		Cable TV		
Child Support		Car Payment		
Alimony		Cell Phone		
Rental Property Income		Day Care		
Food Stamps		Child Support/Alimony		
Other		Prescription Drugs		
Other		**Credit Cards:**		
TOTAL GROSS INCOME:	**$0**	1.		
		2.		
ASSETS		3		
Cash on Hand		**Other Doctor /**		
Savings Account		**Hospital Bills:**		
Checking Account		1.		
C.D.'s		2.		
Securities		3.		
Life Insurance		4.		
Other Real Estate				
Other		**Insurance Expense:**		
		1. Automobile		
Vehicle / Make & Model: **Year** **Value**		2. Property		
		3. Medical / Life		
		Other Loan Payments:		
		1.		
Financial Settlements:		2.		
Life Insurance		**Other Monthly Payments:**		
Inheritance		1.		
Other		2.		
		3.		
TOTAL VALUE OF ASSETS:	**$0**	**TOTAL MONTHLY EXPENSES:**	**$0**	**$0**

COMMENTS:

I hereby certify that the above information is true and complete to the best of my knowledge. I hereby authorize the hospital to obtain information from external credit reporting agencies if the hospital deems necessary.

Date

Signature of Patient, Spouse, Guarantor or Legal Representative