



Application for Hospital Financial Assistance

Any approval of this request is temporary and expires six (6) months from the date of approval

Patient Name: _____ Patient Account #(s) _____

Applicant: _____ Telephone # _____

Responsible Party: _____ Telephone # _____

(if different from Applicant)

Responsible party relationship to patient: _____

Permanent Address: _____

Street (no PO Box numbers) City State Zip

Temporary Address: _____

Street (no PO Box numbers) City State Zip

Live with Relative State from which Drivers License is Issued: _____

Date of Birth: _____ **Social Security # (if issued):** _____ **Driver's License #:** _____

Dependents (spouse / legal dependents* – list all) Total # of People in Family Unit*: _____

Name	DOB/Age	Relationship	Name	DOB/Age	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Marital Status: Married Separated Divorced Unmarried (single or widowed)

Providing the information below on the patient's primary language, race & ethnicity is optional to the patient

Language: English	Non-English
Ethnicity: Hispanic	Non-Hispanic
Race: Asian	American Indian/Alaska Native
Black/African American	Native Hawaiian/Pacific Islander
White/Caucasian	Other or Multiple Races:

Employment:

Patient's Employer: _____ Telephone: _____

Address: _____ How long? _____

Occupation: _____ Weekly / Bi-weekly / Monthly Salary before Deductions:\$ _____

Spouse's Employer: _____ Telephone: _____

Address: _____ How long? _____

Occupation: _____ Weekly / Bi-weekly / Monthly Salary before Deductions:\$ _____

Guarantor's Employer: _____ Telephone: _____

Address: _____ How long? _____

Occupation: _____ Weekly / Bi-weekly / Monthly Salary before Deductions:\$ _____

List all Other Income before Taxes:

Self-employment Income:	\$	W	B	M
Child-care Income:	\$	W	B	M
Rental Income:	\$	W	B	M
Unemployment Compensation:	\$	W	B	M
Temporary Disability Insurance:	\$	W	B	M
Child Support:	\$	W	B	M
Alimony:	\$	W	B	M
Workers' Compensation:	\$	W	B	M
VA Benefits:	\$	W	B	M
Social Security Benefits:	\$	W	B	M
Dividend & Interest Income:	\$	W	B	M
Royalties:	\$	W	B	M
Pensions:	\$	W	B	M
Public Assistance:	\$	W	B	M
Other:	\$	W	B	M

*W = Weekly / B = Bi-weekly / M = Monthly

Other dependent income: _____ \$ _____

Before determination will be made, the following information must be attached:

- | | |
|---|---|
| <input type="checkbox"/> Prior Year Tax Return | <input type="checkbox"/> Letter of Support / Recommendation (if applicable) |
| <input type="checkbox"/> Last 3 Pay Stub(s) | <input type="checkbox"/> Social Security Record of Income (if applicable) |
| <input type="checkbox"/> Bank Statement | <input type="checkbox"/> Proof of permanent residence |
| <input type="checkbox"/> Proof of disability income (if applicable) | <input type="checkbox"/> Proof of declared expenses (if applicable) |
| <input type="checkbox"/> Medical Assistance Notice of Determination | |

Please return all requested information within ten (10) days.

If you have any questions, please contact _____ at _____.

Check any of the locations you have been seen at in the past twelve (12) months:

- | | |
|--|---|
| <input type="checkbox"/> Our Lady of Fatima Hospital | <input type="checkbox"/> St. Joseph Hospital For Specialty Care |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

Are there any other circumstances or situations that may help assist in making a determination?

Consideration of this application is based on the applicant and/or patient following through to obtain whatever Medicaid or third party benefits he/she is entitled to receive.

I request St. Joseph Health Services of Rhode Island to make a determination of eligibility for financial assistance. I understand that if the information I provide is false, I may be denied financial assistance and be liable for payment for the hospital services provided. I hereby attest that the information in this application is complete and correct to the best of my knowledge and that I understand the process and my responsibilities.

Signature of Applicant _____ Date _____
(or Representative)

Definitions:

* Family Unit – means a group of two or more persons related by birth, adoption, marriage, or other legal means who either live together or who live apart and are claimed as dependents.

*Dependent – means qualifying child or qualifying relative as determined by the Internal Revenue Service Regulations (IRS). (Normally dependents you have claimed on your Federal taxes)