



In order to be considered for the Community Free Care Program at Saint Joseph Health Services of Rhode Island, you must complete the application, found on the back of this letter, in its entirety. Any missing information will delay the application process and may result in a denial for free care.

Along with the completed application, you must provide PROOF OF INCOME. Proof of income includes, but is not limited to copies of

- Payroll check stubs
- Social Security check or award letter
- Unemployment check or award letter
- Most recent 1040 income tax return form

If you do not have any income, you will also need to fill out the "Zero Income Declaration" section below in addition to the application.

If proof of income is not returned or the "Zero Income Declaration" is not filled out, your application will not be processed and you will be billed for all services.

Please mail this application and proof of income immediately to:

**Saint Joseph Health Services of Rhode Island/ Patient Financial Services
200 High Service Avenue
North Providence, RI 02904**

Once a completed application is received, you will be notified by mail within 14 days of our decision. If you have any questions about the application form or process, please contact Patient Financial Services at (401) 456-3276. Thank you.

ZERO INCOME DECLARATION

I, _____, am currently unemployed and have zero income. I have not worked for _____ years and I have not filed an income tax return since _____.
My social security number is: _____

I hereby certify that the above information is true and accurate and understand that the hospital will investigate if deemed necessary.

Print Name

Signature

Date

APPLICATION FOR HOSPITAL FINANCIAL AID

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

ST JOSEPHS HEALTH SERVICES OF RI 200 High Service Ave North Providence RI 02904

Patient Name:	Guarantor:
Date of Birth:	Social Security #:
Social Security #:	Home Phone #:
Home Phone #:	Work Phone #:
Home Address:	Relation to Patient:
Work Phone #:	Address:
Occupation/Employer:	Address:

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

LANGUAGE:	English	Non-English
ETHNICITY:	Hispanic	Non-Hispanic
RACE:	Asian	American Indian/Alaska Native
	Black/African American	Native Hawaiian/Pacific Islander
	White	Other or Multiple Races

Please provide the following information for ALL members of the family unit, EXCEPT the Patient and Guarantor

Name & Relationship to Patient:	Date of Birth:
Social Security # (if issued):	
Home Address:	
Employer Name, Address & Phone:	
Name & Relationship to Patient:	Date of Birth:
Social Security # (if issued):	
Home Address:	
Employer Name, Address & Phone:	
Name & Relationship to Patient:	Date of Birth:
Social Security # (if issued):	
Home Address:	
Employer Name, Address & Phone:	

MONTHLY INCOME

ASSETS

Patient's Salary and Wages:	Savings:
Spouse's Salary and Wages:	Checking:
Guarantor's Salary and Wages:	Certificates of Deposit (CDs):
Self-Employment Income:	Money Market Accounts:
Child Care Income:	Savings Bonds:
Rental Income:	Stocks:
Unemployment Compensation:	Bonds:
Temporary Disability Insurance:	Mutual Funds:
Child Support:	IRAs:
Alimony:	401(k)s:
Workers' Compensation:	403(b)s:
VA Benefits:	457s:
Social Security Payments:	Cash-In Value Life Insurance:
Dividend & Interest Income:	Personal Property:
Royalties:	2nd Home & Rental Property:
Pensions:	2nd Motor Vehicle:
Public Assistance:	TOTAL ASSETS:
Other:	
TOTAL MONTHLY INCOME:	TOTAL ANNUAL INCOME:

I request the hospital to make a determination of eligibility for financial aid. I understand that this information is confidential and subject to verification by the hospital. I also understand that if the information I provided is false, I may be denied financial aid 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: _____ Date: _____

Reviewer Signature:	Approval Discount %:
Maximum Income Allowed:	Approved Amount: \$
Denial Comments:	% of Federal Poverty Level: