St. John's Health Foundation Patient Support – Financial Assistance

St. John's Health Foundation offers patient support to qualified applicants who are seeking financial assistance for their care at St. John's Health.

Eligibility Criteria

- Completion of the patient support fund application.
- Applicants must be patients of St John's Health.
- Applications will only be considered for the current calendar year.
- Expenses for services received are eligible under the conditions of the application submitted in the same calendar year.

Covered Expenses

- Billing related to care received at St John's Health.

Application Process and Timeline

- Funding eligibility is determined by a PayNav soft credit check, cross referenced with the Federal Poverty Guidelines. These resources assign a rate of support for each applicant.
- A St. John's Patient Assistance staff member will send notification of eligibility via email or phone.
- Application and/or payment processing may take up to 3 weeks.

Application for Support

Please note that all sections of this application must be completed. If any sections are left blank, we will be unable to consider your request.

Personal Information

Name: _____Date of Birth:_____

Physical Address: _____ City_____ State_____ Zip Code_____

Mailing Address: _____ City_____ State_____ Zip Code_____

Phone: _____ Email:_____

Insurance Information

Circle all types of coverage you have: Medicaid / Medicare / Employer / Marketplace / Disability / Self-Pay / None / Other

Other Personal Data

Marital Status: Married / Single / Divorced / Living with Partner / Shared Household / Other

Number of dependents: _____ Ages of dependents: _____

Annual Household Income $_____

Request for Support

Please list encounters:

_____

_____

_____

Have you ever received funds from St. John's Health Foundation? Yes/No

I understand that my signature on this application is my attestation that all the information included is true and accurate. I also agree to waive my patient privacy rights to allow the information in this application to be shared with my providers and the people necessary to process the application.

Signature of applicant: _____Date: _____

Printed name: _____

Please return your completed application to FinancialAssistance@stjohns.health, Fax# 307-739-7549, or via mail: Attn: St. John's Patient Financial Services PO Box 428 Jackson, WY 83001. For questions, please call # 307-739-4848