APPLICATION FOR PATIENT FINANCIAL ASSISTANCE

Dear Applicant,

We are honored to be able to offer a Patient Financial Assistance program and appreciate the opportunity to help you qualify for this program. The following form will be used as your application for Patient Financial Assistance. Applications that are incomplete will not be processed. Applications are time sensitive. Incomplete applications *may* render your account ineligible for financial assistance. We use a vendor to run a credit check to determine eligibility. Additional documents may be requested and required, including tax returns, pay stubs, additional bank account statements, and other related items.

The basis of financial assistance is the truthful and accurate provision and submission of financial information from the applicant and/or responsible party. Applicants and/or a responsible party who intentionally misrepresent their household information will be automatically disqualified from any consideration whatsoever with regard to financial assistance programs. Intentional misrepresentation determination is the sole right of St. John's Health.

- ☐ **Please complete the application for financial assistance in its entirety- Sign and date**
- ☐ **Include Bank Statements (Previous 60 days, including savings accounts)**
- ☐ **Income Verification (current year W2 form, current year tax return, or current 2 pay stubs)**
- ☐ **Letter of Hardship (Explain Situation)**
- ☐ **If Uninsured: Medicaid Denial Letter**
- ☐ **If Uninsured: Letter from employer regarding available insurance options**
- ☐ **Submit via one of the following methods:**

Email:
Financialassistance@stjohns.health

Mail:
SJH Patient Assistance Team
P.O. Box 428
Jackson, WY 83001

Fax:
(307) 739-7549

For assistance completing the form or if you have any additional questions please contact our Patient Assistance Team Office at (307) 739-4848.
Thank you,
Patient Financial Assistance Committee

APPLICATION FOR PATIENT FINANCIAL ASSISTANCE

STEP 1: Please complete the information below: (All questions *must* be answered)

Patient Name:	Social Security Number:
Address:	Birth Date:
City, State, Zip:	Medical Records Number (Hospital): Medical Records Number (Physician Practices):
Phone:	Email:
Marital Status: (Circle) Single Married Divorced Separated Widowed	

STEP 2: Fill out all income / asset information: If additional space is required please attach a separate sheet with this form

Family Members: Include Self, Spouse, and Children Under 18	Age	Relation To Applicant	Annual Income	Employers Name

If unemployed provide the date employment ended:	Have you applied for unemployment? Yes No
If no reported income, have you applied for disability? Yes No	Are you planning on applying for disability? Yes No

Does anyone in your household receive any of the following types of assistance?		**Amount**
Medicaid / SSI	Yes No	$
Housing	Yes No	$
Child Support	Yes No	$
General Relief	Yes No	$

Financial Account Balances		**Balance**
Checking Account(s)	Yes No	$
Bank Name:		$
Savings Account(s)	Yes No	$
Bank Name:		$

Monthly Expenses		**Monthly Payment**
Real Estate Property	Yes No	$
Rent	Yes No	$
Car Payments	Yes No	$
Student Loans	Yes No	$
Recreational Vehicles	Yes No	$

Monthly Expenses		**Monthly Payment**
Child Support	Yes No	$
Health Insurance	Yes No	$
Other:		$
Other:		$
Other:		$

Declaration: The information provided above is, to the best of my knowledge and belief, complete, accurate and true. I authorize the release of all information which St. John's Health may need to determine whether I qualify for financial assistance through the hospital's indigent care program, any drug manufacture sponsored drug assistance program, or any other federal or state funded medical assistance program, including the verification of my salary or wages, the balance of any bank accounts that I maintain, the cash-in value of any life insurance policy, stocks or bonds which I possess, as well as the value of any real or personal property which I own or am purchasing. Should I be referred to a federal or state funded medical assistance program I authorize St. John's Health to release and obtain all information needed to determine eligibility for that funding. I understand my credit report will be checked. I understand that applying for assistance does not guarantee approval. I understand that the SJH assistance program has no cash value.

Signature Required

Applicants Signature	Date:
Spouse's Signature	Date: