



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:

NRSC Financial Assistance Representative
10330 N. Meridian Street Ste. 200
Indianapolis, Indiana 46290

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

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.	
				3.	
ASSETS			Other Doctor /		
Cash on Hand			Hospital Bills:		
Savings Account			1.		
Checking Account			2.		
C.D.'s			3.		
Securities			4.		
Life Insurance					
Other Real Estate			Insurance Expense:		
Other			1. Automobile		
Vehicle / Make & Model:	Year	Value	2. Property		
			3. Medical / Life		
			Other Loan Payments:		
			1.		
			2.		
Financial Settlements:			Other Monthly Payments:		
Life Insurance			1.		
Inheritance			2.		
Other			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