

## **SJH FINANCIAL ASSISTANCE PROGRAM – ELIGIBILITY CRITERIA**

If you wish to apply for the St. John Health Financial Assistance Program, please complete and return the attached Application. If you have any questions, SJH associates are available to answer your questions, and assist you in the completion of this Application.

Your completed Application will be reviewed for a discount based on your household income and the number of dependent persons within your household. If eligible, the discount percentage ranges from 40% to 100%. If you are not eligible for this program, you will automatically receive a 25% discount on your uninsured medical services.

### **ELIGIBILITY**

In order to qualify for Financial Assistance, please note the following:

- An Application of local, state, or federal aid may be required.
- **Household income must be verified. Please provide proof of household income. (Tax return and/or recent pay stubs) If you have no income, please provide a statement explaining how you are supported financially.**
- Other income sources must also be reported and include: child support, alimony, workers compensation, public assistance, self-employment income, and unemployment income.

### **Financial Assistance is not available for:**

- Co Pays, deductibles and co-insurance.
- Personal items, such as telephone and television expenses.
- Service that is not medically necessary including cosmetic procedures and infertility treatments
- Service covered by insurance in another health care network.
- Over-the-counter pharmaceutical items.

***Determination of Financial Assistance shall only be applicable to the episode of care for which this Application is being completed.***

Mail this application to: Providence Hospital and Medical Centers  
Financial Counselors Office  
16001 W. Nine Mile Rd.  
Southfield, MI 48075   ATTN: Financial Assistance Program

**ST. JOHN HEALTH  
FINANCIAL ASSISTANCE APPLICATION**

*This information will be used by our Medical Center staff to help resolve your financial obligation to St. John Health. All information in this form will be kept confidential.*

**PATIENT INFORMATION**

Account Number : \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Marital Status(circle): S M D W Soc Sec No: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse Cell Phone: \_\_\_\_\_

Medical Insurance: \_\_\_\_\_

**OTHER RELATIVE/EMERGENCY CONTACT INFORMATION**

Other Relative Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Relative Phone: \_\_\_\_\_

Emergency Contact Name : \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_

**EMPLOYMENT/INCOME INFORMATION**

Number of Taxable Dependents: \_\_\_\_\_

Patient's employer(s): \_\_\_\_\_ Hire Date: \_\_\_\_\_

Spouse's employer(s): \_\_\_\_\_ Hire Date: \_\_\_\_\_

If you own a business or are self-employed, describe the business: \_\_\_\_\_

**SOURCES OF INCOME** -please provide proof of household income

	****	*****	Patient ***	****		****	*****	Spouse ***	*****
<u>Income Type</u>	Hourly Rate	Hrs per Wk	Weekly Gross \$	Yearly Gross \$		Hourly Rate	Hrs per Wk	Weekly Gross \$	Yearly Gross \$
Current Job/Business									
Unemployment									
Workers Comp									
Side Jobs									
Child Support									
Other (describe):									
<b>Total Yearly Household Gross \$</b>									

\*\*\*\*\*PLEASE COMPLETE AND SIGN OTHER SIDE\*\*\*\*\*

**ST. JOHN HEALTH**  
**FINANCIAL ASSISTANCE APPLICATION**

**CERTIFICATION**

My signature on this form certifies that all the statements are true to the best of my knowledge and that I have disclosed all facts concerning my finances. I understand and acknowledge that any misrepresentation of my finances in connection with this Application, or any failure to cooperate with efforts to qualify me for programs which may cover the cost of my care (for example, Medicaid, personal injury claim, workmen's compensation) may invalidate any award of Financial Assistance and that I will be financially liable for the services provided. I agree to allow St. John Health or its representatives to request and review a report of my credit and to take other reasonable steps to validate all information provided.

I understand that if I qualify for partial financial assistance I will be responsible for payment of the remaining portion of my bill.

**Statement Regarding Gross Income (before taxes and withholding)**

**My Total Yearly Household Income** (Add the Patient and Spouse Yearly Columns from other side and write the total below):

---

**Statement Regarding Lack of Income**

I am currently unemployed and have no source of income. My living expenses are paid by and provided for as follows:

---

---

---

---

---

---

---

---

**Please Sign Below:**

---

**Patient/Guardian**

**(Date)**