# SJH FINANCIAL ASSISTANCE PROGRAM

If you wish to apply for the St. John Health Financial Assistance Program, please complete 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.
- Proof of household income must accompany this Application. This should include the following: income tax returns from the previous year, recent pay stubs, and, if requested, a current bank statement.
- Other income sources must also be reported and include: child support, alimony, workers compensation, pension, rental income, social security, trust fund, public assistance, self employment income, and unemployment income.

**Program Exclusions**

- Co Pays and deductibles
- Personal items, such as telephone and television expenses.
- Service that is not medically necessary.
- Infertility treatment
- Service covered by insurance in another health care network.
- International patients.
- Over-the-counter pharmaceutical items.

When your Application process is completed you will be notified of the results by mail.
***Determination of Financial Assistance shall only be applicable to the episode of care for which this Application is being completed.***

If you have any questions regarding this policy, please contact__________________.

## SJH FINANCIAL ASSISTANCE PROGRAM INFORMATION

**Patient Name:** ____________________________________________________________

**Medical Insurance:** _________**Account Number (if available)**__________________________

**Type of medical service you are requesting Financial Assistance for**___________________

*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.*

***The following Items are necessary to consider this Application for Financial Assistance. Send copies only, items will not be returned. Incomplete Applications will be denied. If you are married you must provide the requested information for both you and your spouse.***

- **A copy of your most recent pay stubs for the last two months, including year-to-date earnings.**
- **A copy of your monthly income statement for self-employment or a copy of your general business ledger/business checking account summary, if applicable.**
- **A copy of your Social Security, disability, pension, public assistance, workers compensation, trust fund, unemployment, child support, and alimony.**
- **A copy of your most current Federal Income Tax return, if available.**
- **A copy of the most recent bank statements, both checking and savings if requested by St. John Health Staff.**
- **If requested to apply, a copy of your Medicaid denial.**
- **Other:**
  ____________________________________________________________
  ____________________________________________________________
  ____________________________________________________________
  ____________________________________________________________

**IF YOU HAVE NO INCOME, SUBMIT A STATEMENT EXPLAINING HOW YOU ARE BEING SUPPORTED FINANCIALLY, INCLUDING REFERENCES FOR VERIFICATION. (I.E. SUPPORTING FAMILY MEMBERS, SOCIAL WORKER, ETC.)**

**PLEASE SUBMIT A COPY OF YOUR DRIVER'S LICENSE OR STATE ID FOR PROOF OF RESIDENCY.**

SJH Financial Assistance Program

***APPLICANT OR PATIENT INFORMATION:***

**Applicant:**________________________ **Relationship to patient:**__________________________

**Address:**_________________________ **Telephone:**_____________________________________

**City/State/Zip:**_____________________ **Birth Date:**______________________________________

**Soc Sec No:**______________________ **Spouse's Name:**_________________________________

***DEPENDENT INFORMATION:***

| NAME | BIRTH DATE | RELATIONSHIP |
|---|---|---|
| | | |
| | | |
| | | |

***EMPLOYMENT/INCOME INFORMATION:*** **Applicant** ***and*** **Spouse/other**

**Present employer**: _________________________________________________________________

**Hire Date**: ______________________________________________________________________

**Employer address:** _________________________________________________________________

**Gross Pay ☐Weekly ☐Biweekly ☐Monthly: $**_______________**$**______________________________

**Hours scheduled per week:** ____________________________________________________________

**Unemployment Income:** ________________________________________________________________

**If unemployed, Name/Address/Phone# of last employer:** ______________________________________

_____________________________________________________________________________________

**Date of last employment**________________________________________________________________

**Income from rental property**_____________________________________________________________

**Social Security Income:** _________________________________________________________________

**Pension/Retirement income:** _____________________________________________________________

**Worker's Compensation:** _________________________________________________________________

**Alimony/Child Support income:** ___________________________________________________________

**Other (Specify):** _______________________________________________________________

***Motor Vehicles (include boats, motorcycles, trailers, RV's, ATV's, etc.)***

| Type of Vehicle | Year/Make/Model | Value of Vehicle | Amount Owed | Monthly Payment |
|---|---|---|---|---|
| | | | | |
| | | | | |

## SJH Financial Assistance Program

| **MONTHLY EXPENSES** | | **HOUSEHOLD ASSETS** | |
|---|---|---|---|
| House Payment/Rent | $___________ | House Value | $_____________ |
| ***Property expenses not included above:*** | | Other property | $_____________ |
| Taxes | $___________ | Stocks/Bonds | $_____________ |
| Insurance | $___________ | Money Market | $_____________ |
| ***Utilities:*** | | Investments | $_____________ |
| Electric | $___________ | IRA/TSA/401K | $_____________ |
| Gas | $___________ | Trust Fund | $_____________ |
| Water | $___________ | | |
| Telephone | $___________ | | |
| Cable | $___________ | | |
| ***Other:*** | | | |
| Food | $___________ | | |
| Car Payment | $___________ | **Checking Accounts:** | |
| Auto Insurance | $___________ | Name of institution | ____________ |
| Buses/Taxi | $___________ | Current Balance | $____________ |
| Child Support | $___________ | **Savings Accounts:** | |
| Cost of Day Care | $___________ | Name of institution | _____________ |
| Health Insurance | $___________ | Current Balance | $____________ |
| Other Insurance | $___________ | | |
| Total Medical Expenses | $___________ | | |
| Credit Card Expenses | $___________ | | |
| Bank Loans | $___________ | | |
| **Total Monthly Expenses** | $___________ | | |

I understand that failure to complete this form in its entirety, including proof of income, may result in denial of this program. My signature on this form guarantees 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 may invalidate any award of Financial Assistance and that I will be financially liable for the services provided. I understand that I may be responsible for patient co-pays as determined by Patient Financial Services. Failure to satisfy my determined co-pay may result in the denial of continued participation in the SJH Financial Assistance Program.

**Signature** **Date**

**Complete all sections of this form, sign, date, and return it within ten (10) business days.**

**Mail this application to: (PLACE LABEL HERE)**