



To Our Valued Patient:

Thank you for choosing CHRISTUS Health for your healthcare needs. Enclosed you will find an application for financial assistance. Please return the completed application and provide all supporting documentation to the hospital business office.

Patients with a family income at or below 400% of the applicable federal poverty guideline who lack sufficient funds to pay their bills may be eligible for assistance. Patients with significant medical bills regardless of income may also be eligible for assistance. In addition to partial or full adjustments, assistance includes extended payment arrangements.

We understand your desire for privacy. Accordingly, except for verification purposes, the information included in your application will be treated as confidential. It will only be shared within CHRISTUS Health on a need to know basis.

Upon receipt of a completed application, our staff will conduct a review of the application for possible assistance towards the balance on your account(s) with CHRISTUS Health. We will notify you in writing after our review.

Again, we would like to thank you for choosing CHRISTUS Health for your health care needs. If you have any questions regarding the application or the above information, please contact a hospital financial counselor or call the number listed below.

Sincerely,

CHRISTUS Trinity Mother Frances Health System
903-531-5518
Monday – Friday
8:00 AM to 5:00 PM (central)

Please send completed applications to:
CHRISTUS Trinity Mother Frances Business Office
PO Box 6997
Tyler, TX 75711
Or deliver in person to the hospital admitting department or to the business office at 4542 Old Troup Hwy Tyler, TX 75707

Application Date: \_\_\_\_\_ Guarantor Name (if not patient): \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date(s) of Service: \_\_\_\_\_

Hospital Account # \_\_\_\_\_ Medical Record # \_\_\_\_\_

- CHRISTUS St. Michael Hospital
CHRISTUS St. Michael Hospital – Atlanta
CHRISTUS St. Frances Cabrini Hospital
CHRISTUS Coughatta Health Care Center
CHRISTUS Highland Medical Center
CHRISTUS Schumpert
CHRISTUS St. Patrick Hospital
CHRISTUS Hospital – St. Elizabeth
CHRISTUS Hospital – St. Mary
CHRISTUS Jasper Memorial Hospital
CHRISTUS St. Vincent Regional Medical Ctr
Children’s Hospital of San Antonio
CHRISTUS Santa Rosa Hospital – Medical Center
CHRISTUS Santa Rosa Hospital – Westover Hills
CHRISTUS Santa Rosa Hospital – New Braunfels
CHRISTUS Spohn Hospital – Shoreline
CHRISTUS Spohn Hospital – South
CHRISTUS Spohn Hospital – Memorial
CHRISTUS Spohn Hospital – Kleberg
CHRISTUS Spohn Hospital – Alice
CHRISTUS Spohn Hospital – Beeville
CHRISTUS Trinity Mother Frances Health System



# FINANCIAL ASSISTANCE APPLICATION

Patient(s) Name: \_\_\_\_\_ Account #: \_\_\_\_\_

**YOU MUST PROVIDE AT LEAST 1 OF THE FOLLOWING:**

- Most recent and complete Income Tax Return
- 3 most recent pay check stubs
- 3 most recent checking/savings account statements
- Food Stamp or SSI/SSA/SSD award letter
- If you report a \$0 income, please attach a brief explanation of how you or the patient are meeting basic needs

**YOU MUST PROVIDE PROOF OF IDENTITY WITH AT LEAST 1 THE FOLLOWING:**

- Current Driver's License     Alien Registration
- Passport     State-Issued Identification Card

PERSONAL DATA:	RESPONSIBLE PERSON	SPOUSE
Name	_____	_____
Social Security #	_____	_____
Date of Birth	_____	_____
Street Address/Apt. #	_____	_____
City, State, Zip	_____	_____
Home Phone #	_____	_____

**EMPLOYMENT DATA:**

Employer Name	_____	_____
Explain, if self-employed	_____	_____
Address	_____	_____
Phone #	_____	_____
# of Hours Worked/Week	_____	_____
Job Title	_____	_____
Length of Employment	Yrs _____ Months _____	Yrs _____ Months _____
Gross Monthly Salary	_____	_____

**OTHER HOUSEHOLD MEMBERS:**

Name _____	Age _____	DOB _____	Relationship _____
Name _____	Age _____	DOB _____	Relationship _____
Name _____	Age _____	DOB _____	Relationship _____
Gross Monthly Salary _____			

**ADDITIONAL INCOME:**

- 2nd Job:  N  Y: \$ \_\_\_\_\_/month
- Small Business:  N  Y: \$ \_\_\_\_\_/month
- Other: (ex. investments, savings, child support, other governmental aid) \$ \_\_\_\_\_/month

**DEBT:**

- Home Mortgage: \$ \_\_\_\_\_/month
- Held by: \_\_\_\_\_
- Unpaid Balance: \$ \_\_\_\_\_
- Automobile/Boat/RV etc: \$ \_\_\_\_\_/month

**OTHER EXPENSES:**

- Medical Bills: \$ \_\_\_\_\_/month
- Pharmacy Bills: \$ \_\_\_\_\_/month
- Other: (ex. loans, rent, cable, gas phone, utilities, food) \$ \_\_\_\_\_/month

Are any third parties potentially liable for your medical expenses (i.e. auto insurance, workers' compensation, lawsuit)?  Yes  No

I certify that I am unable to pay for all the costs of necessary services and that the information I have given to CHRISTUS Health is true and accurate. I understand that CHRISTUS Health will use this information to determine my eligibility for financial assistance. I have disclosed all my assets and income. Failure to report assets or income could result in legal recourse, including criminal charges. I agree to report any changes in my financial status to CHRISTUS Health. I authorize CHRISTUS Health, or any credit reporting agency, to investigate any reference, statements, employment, or other data given by me or any other person pertaining to my credit and financial responsibility.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_