

RE: Patient –
Account Number –
Date of Service and/or Balance Due –

You have indicated that you need assistance with your hospital bill. In order for us to evaluate your financial situation, the following documents are required:

$\boxtimes$	A completed <b>Financial Evaluation Form</b> (enclosed);
X X X	A copy of your most current Federal tax form(s) with ALL schedules, including W-2(s);
$\boxtimes$	A copy of your most recent three (3) paycheck stubs for you and anyone working
within :	your household;
$\boxtimes$	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
$\boxtimes$	The name and telephone number for your Medicaid caseworker, if applicable.
$\boxtimes$	Other:

Please be advised that if the information requested is not received within the next 30 days, we will continue our normal billing practice.

Thank you for your cooperation.

Please return to:

St. Vincent Health Patient Financial Services 10330 North Meridian St. Suite 200 Indianapolis, IN 46290

Should you have additional questions, please contact Customer Service at 866-435-2078.



## **Financial Evaluation Long Form**

MR Number & Account Number to be completed by hospital personnel		Number:		Hospital	Hospital		Account Number:	
					ely. Information is subjected are more than five (5)		ion.	
Patient's Name (First, MI, Last):				Social Security			# Household Members	
Address:		T		mbers:				
			Home: ( ) Work: (		)			
City/ST/Zip:				Responsible F	Party Name (First, MI, Last):			
List ALL household member names	Date	e of Birth	Soc Sec	Number	Relationship to pa	itient	Monthly Income	
1.			-	-		ļ	\$	
2.			-	-			\$	
3.			-	-			\$	
4.			-	-			\$	
5.			-	-			\$	
Monthly Inco	ome			Monthly Expenses				
Responsible Party's Gross Income (before t	taxes)	\$	j		Rent/Mortgage/Homeowner's Insurance		\$	
Other Household Gross Income (before taxes)		\$		Utilities (Electricity/ Water/Gas)			\$	
Investment Income (Annuities/Stocks/Divide	ends)	\$		Telephone		\$		
Child Support/Alimony Received		\$		Child Support/Alimony Paid			\$	
Rental Property Income		\$		Food (excluding cigarettes & alcoholic beverages)			\$	
Pension/Retirement/Unemployment		\$		Car Payment (loan + insurance)			\$	
Other:		\$		Medical & Pharmacy Bills		\$		
Total Monthly Income (before ta	\$		Total Monthly Expenses		\$			
Assets				Liabilities				
Value of Residence(s)		\$		Residence Loan Balance/Mortgage		\$		
Checking Account Balance		\$		Balance Owed on Credit Cards			\$	
Savings/Money Market/CD's/Retirement Funds		\$		Auto Loan Balance		\$		
Value-Auto/Boat/Motorcycle		\$		Total Medical Bills (attach list)		\$		
Other:		\$		Real Estate Taxes		\$		
Total Value of As	\$		Total Liabilities		iabilities	\$		
I certify that the informationalso certify that there is no additional understand that providing false in through St. Vincent Health. If I and action necessary or requested by	nal ins inform m ent	urance cov ation will i itled to an	verage for result in d y action a	this patient enial of the gainst or s	other than what was a application for any ettlement from third p	listed at tin type of fina party payer	ne of registration. ancial assistance rs, I will take any	

also certify that there is no additional insurance coverage for this patient other than what was listed at time of registration. I understand that providing false information will result in denial of the application for any type of financial assistance through St. Vincent Health. If I am entitled to any action against or settlement from third party payers, I will take any action necessary or requested by St. Vincent Health to obtain such assistance and will assign to St. Vincent Health, and upon receipt will pay to St. Vincent Health, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by St. Vincent Health will result in the denial of this application. I also authorize St. Vincent Health to check my credit history through the credit bureau, if deemed appropriate.

Signature of Patient (Responsible Party)	Date



## Proof of Income for Self-Employed Patients/Responsible Party Worksheet

Dear :

It is our understanding that you have requested financial assistance for your healthcare services and are unable to produce the normal routine documentation due to your self-employed status. Please provide the following information for the last eight (8) weeks:

Week	Business Inco	me Busines	s Expenses	Your "Take Home" Pay	
1	\$ .	\$		\$	
2	\$ .	\$		\$	
3	\$ .	\$		\$	
4	\$ .	\$		\$	
5	\$ .	\$		\$	
6	\$ .	\$		\$	
7	\$ .	\$		\$	
8	\$ .	\$		\$	
Total	\$ .	\$		\$	

Return this information immediately upon completion to:

St. Vincent Health Patient Financial Services 10330 North Meridian St. Suite 200 Indianapolis, IN 46290

Sincerely,

St. Vincent Health