Trinity Health

20555 Victor Parkway
Livonia, Michigan 48152

Case Number: XXXXXX
patient name

Financial Assistance Documentation - Letter of Support

Patient name: _____ Date of Birth: _____ Account #:_____

I _____ state that _____
(*Person signing Letter of Support, please print)* *(Patient Name, please print)*

currently lives with me at

_____ _____ _____ _____
Address City State Zip Code

Please check all situations that apply:

____ I provide food and shelter, but I am unable to provide assistance for medical bills.

____ I provide more than 50% support for the patient's living expenses.

By signing this letter, I verify that the above statement(s) is(are) correct and that I will in no way be held liable for the patient's bills. If you have questions, please contact me at _____.

_____ _____ _____
Signature of person providing support Relation to Patient Date

(For Hospital Use Only)
Application Origin: _____
Account #'s: _____

Please mail your application to the address below. If you have any questions please contact our Customer Service Center at 866-626-7272 between 9:00 am - 5:00 pm (M-F).

Sincerely,

Trinity Health
Enterprise Patient Financial Services
2055 Victor Parkway
Livonia MI 48152

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CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE

For Hospital and Professional services provided by affiliated facilities and physicians of Trinity Health

Patient Name		Date of Birth
Street Address	Telephone	Msg Phone
City/State/Zip		Social Security Number (Optional)
Mailing Address (if different)		
Are you a citizen of the United States? □ Yes □ No		
What state are you a resident of?		
What is your current marital status? *Married* *Widowed* *Divorced* *Separated* *Never married* *Living with partner*		
Can you be claimed as a dependent on someone else's tax return? □ Yes □ No		
Do you have dependent children in your household that you claim on your tax return? □ Yes □ No		
If you have dependent children – Do they currently have Medicaid? □ Yes □ No		
Are you pregnant or have you been pregnant in the last 3 months? □ Yes □ No		

Please provide the following for all household members:

Name	Date of Birth	Relationship to Patient

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Application

Do you have Medicaid and/or Medicare?	□ No	□ Yes	If Yes, Name/ID	
Have you applied for Medicaid within the last 30 days?	□ No	□ Yes		
If No – Did you apply for insurance through the Health Insurance Marketplace?	□ No	□ Yes	If No, please select reason and provide documentation	☐ I did not qualify ☐ I cannot afford the premium ☐ I am exempt from penalties ☐ Other:please include letter of explanation with application
Do you or anyone in the household have another health insurance including VA, COBRA, commercial or Retiree plan?	□ No	□ Yes		
Have you applied for Disability?	□ No	□ Yes	If Yes, when?	
Are you seeking medical services as a result of a violent crime inflicted by another person?	□ No	□ Yes	If Yes, has a police report been filed?	Police Report #
Are you seeking medical services due to an auto or other accident? Do you have Auto Insurance?	□ No □ No	□ Yes □ Yes	If Yes, has a police report been filed?	Police Report # Name of Auto Insurance: Adjuster Name:

Employment

Person Employed	Employer	Gross Pay	Per:	Monthly Gross
			□ WK □ 2Wk □ Month	
			□ WK □ 2Wk □ Month	

Monthly Household Income from Other Sources

Source	**Monthly**	**Annually**
Alimony	$	$
Federal Assistance Program Type (i.e. Cash, Food Stamps etc.)	$	$
Pension / Annuity Cash out	$	$
Social Security / Social Security Disability	$	$
Unemployment or Worker's Comp (Start Date: MM/DD/YY End Date: MM/DD/YY)	$	$
Other Income (Stocks/Bonds/Annuities/Interest/Rental Property)	$	$

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Total Monthly Gross Income from Other Sources	$	$

Monthly Household Liabilities/Expenses: Complete ONLY if expenses significantly exceed income

Rent / Mortgage, Balance:	$
Grocery Expense	$
Child Care	$
Child Support or Alimony	
Utilities: Gas - Electric Water / Sewer Phone (cell/home)	$
Medication Expenses (co-pay / cash pay etc.)	$
Unpaid Medical Expenses (i.e. doctor, dental, hospital, other providers) Please provide a detailed list with copies of most recent bills if available	$
Health Insurance Premiums	$
Car Loan Payments	$
Transportation (Bus, Taxi)	$
Loan Payment Type: Balance:	$
Credit Card Payment(s) Total Balance(s) Owed:	$

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VERIFICATION OF INCOME AND IDENTIFICATION

I hereby authorize Saint Alphonsus Medical Center Nampa to release information on file to assist in the enrollment of various health and human service programs for which I apply. I understand this information may include financial information, medical information and/or any other information contained in my file.

The U.S. Department of Health and Human Services (HHS) enforces the federal privacy regulations commonly known as the HIPAA Privacy Rule (HIPAA). HIPAA requires most doctors, nurses, pharmacies, hospital, nursing homes and other health care providers to protect the privacy of your health information. Even though HIPAA requires health care providers to protect your privacy, providers are permitted, in most circumstances to communicate with the patient's family, friends, or others involved in their care or payment for care.

I authorize Trinity Health to use the information provided on my Medicaid application to determine my eligibility for financial assistance. I understand that I may be asked to provide additional information and documentation to complete my financial assistance application

I certify that the information listed in this application is true and complete to the best of my knowledge. I understand that the information provided will be verified and treated as personal and confidential. I also understand that I will be liable for repayment of any services rendered at Trinity Health affiliates if the above information is given under false pretenses.

SIGNATURE OF PATIENT: _____ DATE: _____

SIGNATURE OF SPOUSE: _____ DATE: _____

(If Applicable)

OR SIGNATURE OF LEGAL GUARDIAN:_____DATE:_____

RELATIONSHIP TO PATIENT: _____DATE: _____

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FINANCIAL ASSISTANCE REQUIRED VERIFICATIONS

If you are under age 21, age 65 or older, pregnant, blind, disabled or a parent or close relative living with and acting as a parent for a child under the age of 18 or eligible for a state assistance program, we will require a Medicaid Determination to review your accounts for Financial Assistance.

- Medicaid Determination

If you are uninsured, we will require that you enroll in the Health Insurance Marketplace (if applicable) before we are able to review your accounts for Financial Assistance. If you have enrolled and have documentation or have received an exemption from enrollment, please provide documentation with your application. If you are not able to obtain this documentation, we will require you fill out the Health Insurance Marketplace Attestation Document.

- Marketplace Attestation

Income Verifications

Employment Income - Past 30 days consecutive check stubs, showing gross amount

Self-employed, rental or farm income

- Three most recent months of Profit/Loss forms
- Previous year tax documents (1040 form with Schedule C, E or F)

No Income – Provide Letter of Support that includes person's name, relationship to patient, and phone number

Social Security Income - Past 30 days bank statement showing direct deposits or Social Security Benefit Letter

Unemployment Income - Past 30 days bank statement showing direct deposits or Unemployment Benefit Letter

Child Support Income - Past 30 days bank statement showing direct deposits or court document showing awarded amount

Pension or Monthly Annuity Payments - Past 30 days bank statement showing direct deposits or award letter

Seasonal Employment Income – Copy of your most recent W2(s) or completed Tax Return

Savings/Checking Account - Past 60 days bank statements for each account