CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE OR DISCOUNTED PAYMENT

Personal & Confidential

Thank you for selecting Saint Agnes Medical Center as your health care provider. Please complete the enclosed application and return it to the address below to complete the evaluation of your discounted payment or financial assistance.

Note: patients who only apply for discount payment may receive less financial assistance than what may be available under the Saint Agnes Charity Adjustment Guidelines.

If you have any questions, please contact our Customer Service Center at 1-866-626-7272., Monday through Friday between 9:00 a.m. - 5:00 p.m. ET.

SINCERELY,

TRINITY HEALTH ENTERPRISE PATIENT
FINANCIAL SERVICES ON BEHALF OF SAINT
AGNES MEDICAL CENTER
20555 VICTOR PARKWAY
LIVONIA, MI 48152

CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE OR DISCOUNTED PAYMENT

Please complete and sign the application form and return including copies of the following:

Required Verifications

□ Prior paystubs within a 6-month period before or after the patient is first billed by the hospital (or in the case of preservice, when the application is submitted).

OR

□ Copy of Federal Income Tax Return (Form 1040) from the year the patient was first billed or up to 12 months prior to when the patient was first billed.

You may submit other forms of proof of income if you wish, but no additional proof of income is required by the hospital. If you have no proof of income or no income, you may attach a page with an explanation.

Patient Information

Patient Name		Date of Birth	
Social Security/EIN Number (optional)	Mobile Phone	Other Phone	
Mailing Address	City	State	ZIP code
Email Address	Of what state are you a resident?		
Marital status □Single □Married □Divorced □Other _____			
Do you file a Federal Tax Return? □ Yes □ No If no, why?	Can you be claimed as dependent on someone else's tax return? □ Yes □ No		
Did you or your dependents have health insurance coverage at the time of service? □ Yes □No (Provide Insurance card copy)			
Are you a documented resident of the United States? □ Yes □ No □ Prefer Not to Answer			

Household Members, including yourself based on your recent Tax Returns	Date of Birth	Relationship to Patient	Claimed on Tax Return (Yes/No)

Income Verification for all household members

Monthly Income Source	Who receives this?	Gross Monthly Income (before taxes)	Monthly Income Source	Who receives this?	Gross Monthly Income (before taxes)
Wages			Worker's Compensation		
Social Security/Disability			Unemployment		
Pension			Child Support/Alimony		
Self-Employment			Rental Land Income		
Public Assistance			Other		

Letter of Financial Support - Should only be completed by the person providing support

I provide more than 50% support for the patient's living expenses, but I am unable to help with medical bills.
By signing this letter, I verify that the above statement is correct and that I will in no way be held liable for the patient's bills. If you have questions, please contact me at (Phone Number)

Name of person providing support	Relationship to Patient
Signature of person providing support	Date

VERIFICATION OF INCOME AND IDENTIFICATION

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 is subject to verification. I will be responsible for repayment of any services provided at Trinity Health affiliates if the above information is provided under false pretenses.

Signature of Patient: _____ Date: _____

Or Signature of Legal Guardian (If Applicable): _____Date: _____

Relationship to Patient: _____ Date: _____

Please mail your application to the address above, fax at 312-871-3350 and or upload documents through MyChart (Patient Portal) - https://mychart.trinity-health.org/MyChart If you have any questions, please contact our Customer Service Center at 1-866-626-7272 Monday through Friday 9 a.m. -5 p.m. ET.