1150 Varnum St. NE
Washington, DC 20017

PROVIDENCE HOSPITAL FINANCIAL ASSISTANCE PROGRAM

APPLICATION INSTRUCTIONS:

If you wish to apply for the Providence Hospital Financial Assistance Program, please complete and return the attached Application. If you have any questions, Providence Hospital 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 70% to 100%. If you are not eligible for this program, you will automatically receive a 65% discount on your uninsured medical services.

ELIGIBILITY
In order to qualify for Financial Assistance, please note the following:

- An Application for local, state, or federal aid may be required.
- **Household income must be verified. Please provide proof of household income. (Tax return and/or recent pay stubs) If you have no income, please provide a statement explaining how you are supported financially.**
- Other income sources must also be reported and include: child support, alimony, workers compensation, public assistance, self-employment income, and unemployment income.

Financial Assistance is not available for:
- Personal items, such as television expenses.
- Service that is not medically necessary including cosmetic procedures and infertility treatments
- Service covered by insurance in another health care network.
- Over-the-counter pharmaceutical items.

Determination of Financial Assistance shall only be applicable to the episode of care for which this Application is being completed.

Mail application to: Providence Hospital
ATTN: Financial Counseling & Eligibility Services (Ground Flr)
1150 Varnum St., NE
Washington, DC 20017

Fax this application to: (202) 281-3143

Questions regarding this application: (202) 854-4081

FINANCIAL ASSISTANCE APPLICATION

PATIENT INFORMATION (PLEASE PRINT)

Patient Name:	Birth Date	Marital Status	Sex		Account No. / Telephone No.

Address:	City	State	Zip	Email Address

Social Security Number:	Employer	Full Time / Part Time		How many hrs/wk

Employer Address:	City	State	Zip	Telephone No.

RESPONSIBLE PARTY'S INFORMATION

Name Same as above	Birth Date	Marital Status	Sex		Telephone No.

Address	State	Zip	Email Address

Social Security Number	Employer	Full Time / Part Time		How many hrs/wk

Employer Address	City	State	Zip		Telephone No.

RESPONSIBLE PARTY SPOUSE INFORMATION

Spouse's Name	Social Security Number	Birth Date

Spouse's Employer:	Address:	City	State	Zip	Telephone No.

DEPENDENTS:

Name	Age	Relationship	Name	Age	Relationship

GROSS MONTHLY INCOME	
Applicant Earned Income	
Applicant Spouse's Income	
Social Security Benefits	
Pension/Retirement Income	
Unemployment Compensation	
Worker's Compensation	
Interest / Dividend Income	
Child Support	
Alimony	
Rental Property Income	
Food Stamps	
Other	
Other	
TOTAL GROSS INCOME:	

ASSETS	
Cash on Hand	
Savings Account	
Checking Account	
C.D.'s	
Securities	
Life Insurance	
Other Real Estate	
Other	

Vehicle / Make & Model:	Year	Value

Financial Settlements:	
Life Insurance	
Inheritance	
Other	
TOTAL VALUE OF ASSETS:	

MONTHLY LIVING EXPENSES	Payment	Balance
Mortgage/Rent		
Electricity		
Gas		
Telephone		
Water		
Groceries		
Cable TV		
Car Payment		
Cell Phone		
Day Care		
Child Support/Alimony		
Prescription Drugs		
Credit Cards:		
1.		
2.		
3		
Other Doctor / Hospital Bills:		
Insurance Expense:		
1. Automobile		
2. Property		
3. Medical / Life		
Other Loan Payments:		
1.		
2.		
Other Monthly Payments:		
cobra		
life insurance		
3.		
TOTAL MONTHLY EXPENSES:		

COMMENTS: _____

I hereby certify that the above information is true and complete to the best of my knowledge. I hereby authorize the hospital to obtain information from external credit reporting agencies if the hospital deems necessary.

Date

Signature of Patient, Spouse, Guarantor or Legal Representative

PROVIDENCE HOSPITAL
FINANCIAL ASSISTANCE APPLICATION

CERTIFICATION

My signature on this form certifies 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, or any failure to cooperate with efforts to qualify me for programs which may cover the cost of my care (for example, Medicaid, personal injury claim, workmen's compensation) may invalidate any award of Financial Assistance and that I will be financially liable for the services provided. I agree to allow Providence Hospital or its representatives to request and review a report of my credit and to take other reasonable steps to validate all information provided.

I understand that if I qualify for partial financial assistance I will be responsible for payment of the remaining portion of my bill.

Statement Regarding Gross income (before taxes and withholding)

My Total Yearly Household Income (add the Patient and Spouse Yearly Columns from other side and write the total below):

_____

Statement Regarding Lack of Income

Briefly describe your financial/living situation and why you need financial assistance with your medical bill(s).

_____

_____

_____

_____

_____

_____

_____

_____

Please Sign Below:

_____

Patient /Guardian (Date)