Sacred Heart Health System, Inc.
d/b/a Ascension Sacred Heart,
d/b/a Ascension Sacred Heart Pensacola
d/b/a Ascension Sacred Heart Emerald Coast
d/b/a Ascension Sacred Heart Gulf
Bay County Health System, LLC
d/b/a Ascension Sacred Heart Bay

FINANCIAL ASSISTANCE POLICY

7/1/24

POLICY/PRINCIPLES

It is the policy of the organizations listed below this paragraph (each one being the "Organization") to ensure a socially just practice for providing emergency and other medically necessary care at the Organization's facilities. This policy is specifically designed to address the financial assistance eligibility for patients who are in need of financial assistance and receive care from the Organization.

1. All financial assistance will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship.

2. This policy applies to all emergency and other medically necessary care provided by the Organization, including employed physician services and behavioral health. This policy does not apply to charges for care that is not emergency and other medically necessary care.

3. The List of Providers Covered by the Financial Assistance Policy provides a list of any providers delivering care within the Organization's facilities that specifies which are covered by the financial assistance policy and which are not.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- "**501(r)**" means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.
- "**Amount Generally Billed**" or "**AGB**" means, with respect to emergency and other medically necessary care, the amount generally billed to individuals who have insurance covering such care.
- "**Community**" means Sacred Heart Health System, Inc., d/b/a/ Ascension Sacred Heart, d/b/a Ascension Sacred Heart Pensacola to include Escambia and Santa Rosa counties, d/b/a Ascension Sacred Heart Emerald Coast to include Okaloosa and Walton counties, d/b/a Ascension Sacred Heart Gulf to include Gulf and Franklin counties, and Bay County Health System to include Bay County. A Patient will also be deemed to be a member of the Organization's Community if the emergency and medically necessary care the Patient requires is continuity of emergency and medically necessary care received at another Ascension Health facility where the Patient has qualified for financial assistance for such emergency and medically necessary care.
- "**Emergency care**" means [care to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention

may result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or placing the health of the individual in serious jeopardy.

- "**Medically necessary care**" means care that is (1) appropriate and consistent with and essential for the prevention, diagnosis, or treatment of a Patient's condition; (2) the most appropriate supply or level of service for the Patient's condition that can be provided safely; (3) not provided primarily for the convenience of the Patient, the Patient's family, physician or caretaker; and (4) more likely to result in a benefit to the Patient rather than harm. For future scheduled care to be "medically necessary care," the care and the timing of care must be approved by the Organization's Chief Medical Officer (or designee). The determination of medically necessary care must be made by a licensed provider that is providing medical care to the Patient and, at the Organization's discretion, by the admitting physician, referring physician, and/or Chief Medical Officer or other reviewing physician (depending on the type of care being recommended). In the event that care requested by a Patient covered by this policy is determined not to be medically necessary by a reviewing physician, that determination also must be confirmed by the admitting or referring physician.
- "**Organization**" means Sacred Heart Health System, Inc., d/b/a Ascension Sacred Heart, d/b/a Ascension Sacred Heart Pensacola, d/b/a Ascension Sacred Heart Emerald Coast, d/b/a Ascension Sacred Heart Gulf, and Bay County Health System, LLC, d/b/a Ascension Sacred Heart Bay
- "**Patient**" means those persons who receive emergency and other medically necessary care at the Organization and the person who is financially responsible for the care of the patient.

Financial Assistance Provided

Financial assistance described in this section is limited to Patients that live in the Community:

1. Subject to the other provisions of this Financial Assistance Policy, Patients with income less than or equal to 250[1]% of the Federal Poverty Level income ("FPL"), will be eligible for 100% charity care on that portion of the charges for services for which the Patient is responsible following payment by an insurer, if any, if such Patient determined to be eligible pursuant to presumptive scoring (described in Paragraph 5 below) or submits a financial assistance application (an "Application") on or prior to the 240th day after the Patient's first discharge bill and the Application is approved by the Organization. Patient will be eligible for up to 100% financial assistance if Patient submits the Application after the 240th day after the Patient's first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges.

2. Subject to the other provisions of this Financial Assistance Policy, Patients with incomes above 250[2]% of the FPL but not exceeding 400[3]% of the FPL, will receive a sliding scale discount on that portion of the charges for services provided for which the Patient is responsible following payment by an insurer, if any, if such Patient submits an Application on or prior to the 240th day after the Patient's first discharge bill and the Application is approved by the Organization. Patient will be eligible for the sliding scale discount financial assistance if Patient submits the Application after the 240th day after the Patient's first discharge bill, but

then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges. The sliding scale discount is as follows:

Ascension Sacred Heart Pensacola

- Patients between 251% FPL and 300% FPL will receive 90% assistance
- Patients between 301% FPL and 330% FPL will receive 75% assistance

Ascension Sacred Heart Emerald Coast

- Patients between 251% FPL and 300% FPL will receive 90% assistance
- Patients between 301% FPL and 348% FPL will receive 80% assistance

Ascension Sacred Heart Gulf

- Patients between 251% FPL and 300% FPL will receive 90% assistance
- Patients between 301% FPL and 331% FPL will receive 80% assistance

Ascension Sacred Heart Bay

- Patients between 251% FPL and 300% FPL will receive 90% assistance
- Patients between 301% FPL and 354% FPL will receive 82% assistance

3. Subject to the other provisions of this Financial Assistance Policy, a Patient with income greater than 400[4]% of the FPL may be eligible for financial assistance under a "Means Test" for some discount of Patient's charges for services from the Organization based on a Patient's total medical debt. A Patient will be eligible for financial assistance pursuant to the Means Test if the Patient has excessive total medical debt, which includes medical debt to Ascension and any other health care provider, for emergency and other medically necessary care, that is equal to or greater than such Patient's household's gross income. The level of financial assistance provided pursuant to the Means Test is the same as is granted to a patient with income at 400[10]% of the FPL under Paragraph 2 above, if such Patient submits an Application on or prior to the 240th day after the Patient's first discharge bill and the Application is approved by the Organization. Patient will be eligible for the means test discount financial assistance if such Patient submits the Application after the 240th day after the Patient's first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges.

4. A Patient may not be eligible for the financial assistance described in Paragraphs 1 through 3 above if such Patient is deemed to have sufficient assets to pay pursuant to an "Asset Test." The Asset Test involves a substantive assessment of a Patient's ability to pay based on the categories of assets measured in the FAP Application. A Patient with such assets that exceed that exceed 250% of such Patient's FPL amount may not be eligible for financial assistance.

5. Eligibility for financial assistance may be determined at any point in the revenue cycle and may include the use of presumptive scoring for a Patient with a sufficient unpaid balance within the first 240 days after the Patient's first discharge bill to determine eligibility for 100% charity care notwithstanding Patient's failure to complete a financial assistance application ("FAP Application"). If Patient is granted 100% charity care without submitting a completed FAP Application and via presumptive scoring only, the amount of financial assistance for which Patient is eligible is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A determination of eligibility based on presumptive scoring only applies to the episode of care for which the presumptive scoring is conducted.

6. For a Patient that participates in certain insurance plans that deem the Organization to be "out-of-network," the Organization may reduce or deny the financial assistance that would otherwise be available to Patient based upon a review of Patient's insurance information and other pertinent facts and circumstances.

7. The Patient may appeal any denial of eligibility for Financial Assistance by providing additional information to the Organization within fourteen (14) calendar days of receipt of notification of denial. All appeals will be reviewed by the Organization for a final determination. If the final determination affirms the previous denial of Financial Assistance, written notification will be sent to Patient. The process for Patients and families to appeal the Organization's decisions regarding eligibility for financial assistance is as follows:
   a. All appeals will need to be submitted in writing via mail to: Ascension Sacred Heart, Financial Counseling Manager, P O Box 2488, Pensacola, FL 32513
   b. All appeals will be considered by the Organization's financial assistance appeals committee, and decisions of the committee will be sent in writing to the Patient or family that filed the appeal.

Other Assistance for Patients Not Eligible for Financial Assistance

Patients who are not eligible for financial assistance, as described above, still may qualify for other types of assistance offered by the Organization. In the interest of completeness, these other types of assistance are listed here, although they are not need-based and are not intended to be subject to 501(r) but are included here for the convenience of the community served by the Organization.

1. Uninsured Patients who are not eligible for financial assistance will be provided a discount based on the discount provided to the highest-paying payor for that Organization. The highest paying payor must account for at least 3% of the Organization's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the Organization's business for that given year.
2. Uninsured and insured Patients who are not eligible for financial assistance **may** receive a prompt pay discount. The prompt pay discount may be offered in addition to the uninsured discount described in the immediately preceding paragraph.

Limitations on Charges for Patients Eligible for Financial Assistance

Patients eligible for Financial Assistance will not be charged individually more than AGB for emergency and other medically necessary care and not more than gross charges for all other medical care. The Organization calculates one or more AGB percentages using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with 501(r). A free copy of the AGB calculation description and percentage(s) may be obtained on the Organization's website or by calling out Customer Service Department.

Applying for Financial Assistance and Other Assistance

A Patient may qualify for financial assistance through presumptive scoring eligibility or by applying for financial assistance by submitting a completed FAP Application. The FAP Application and FAP Application Instructions are available on the Organization's website at https://healthcare.ascension.org/Billing/Florida or visiting any Patient Registration department or via mail by calling our Customer Service Department. The Organization will require the uninsured to work with a financial counselor to apply for Medicaid or other public assistance programs for which the patient is deemed to be potentially eligible in order to qualify for financial assistance (except where eligible and approved via presumptive scoring). A Patient may be denied financial assistance if the Patient provides false information on a FAP Application or in connection with the presumptive scoring eligibility process, if the patient refuses to assign insurance proceeds or the right to be paid directly by an insurance company that may be obligated to pay for the care provided, or if the patient refuses to work with a financial counselor to apply for Medicaid or other public assistance programs for which the patient is deemed to be potentially eligible in order to qualify for financial assistance (except where eligible and approved via presumptive scoring). The Organization may consider a FAP Application completed less than six months prior to any eligibility determination date in making a determination about eligibility for a current episode of care. The Organization will not consider a FAP Application completed more than six months prior to any eligibility determination date.

Billing and Collections

The actions that the Organization may take in the event of nonpayment are described in a separate billing and collections policy. A free copy of the billing and collections policy may be obtained on the Organization's website or by calling Customer Service @ 1-866-869-9677.

Interpretation

This policy, together with all applicable procedures, is intended to comply with and shall be interpreted and applied in accordance with 501(r) except where specifically indicated.

Exhibit A

Sacred Heart Health System, Inc.
d/b/a Ascension Sacred Heart
d/b/a Ascension Sacred Heart Pensacola
d/b/a Ascension Sacred Heart Emerald Coast
d/b/a Ascension Sacred Heart Gulf
Bay County Health System, LLC
d/b/a Ascension Sacred Heart Bay

LIST OF PROVIDERS COVERED BY THE FINANCIAL ASSISTANCE POLICY

7/1/24

The list below specifies which providers of emergency and other medically necessary care delivered in the hospital facility are covered by the Financial Assistance Policy (FAP). ***Please note that any care that is not emergency and other medically necessary care is not covered by the FAP for any providers.***

PHYSICIANS COVERED BY THE FAP:

Andrew Ringel, MD
Baptist Medical Group – Ladies First
• Regina McCutcheon, MD
Bluewater Orthopedics, PA
• Thomas M. Fox, DO
Carla J. Hinds, MD
Child Neurology Center of NW FL
• James B. Renfroe, MD
Envision Physician Services
Escambia Community Clinic, Inc.
Hospitalist Solutions of Pensacola
• Sylvia V. Harris, MD
Henghold Skin Health & Surgery Group
Louise M. Makarowski, PHD
LogixHealth
Martin & Plunkett M.D. LLC
Nephrology Associates of the Gulf Coast
Julie A. Zemaitis DeCesare, MD
Oral & Maxillofacial Associates
• Kevin C. Dean, DMD
• Aaron C. Wallender, DMD
Panhandle Anesthesiology Associates, PA
• Theresa M. Northern, DO
Pediatric Associates P.A
• Samuel F. Ravenel, MD
Pensacola Lung Group
• Enrique Diaz Guzman Zavala, MD
Pensacola Nephrology, PA
• Douglas L. Bunting, MD
• Edward L. Friedland, MD
• Humam Humeda, MD
• Derek Jimenez, MD
• Douglas S. Keith, MD
• James P. Martin, MD

PHYSICIANS NOT COVERED BY THE FAP:

21ST Century Oncology
ABC Pediatrics
Advanced Geriatrics & Primary Care, LLC
Advanceed Women's Care
AHF Pensacola Healthcare Center
ALC Consulting
All Seasons Allergy & Asthma Center
Amir Razavi, MD
Andrew E. Kortz, MD
Andrews Institute
Baptist Medical Group, LLC
Baptist Physician Associates, LLC
Bay Foot and Ankle Center
Ben Brown MD Plastic & Reconstructive Surgery
Billy C. Weinsten, MD
Bluewater Orthopedics, PA
Bluewater Plastic Surgery
Brooks Foot & Ankle Associates
Calvin L Blount Jr., MD
Cardiovascular Institute of NWFL
Center for Prevention and Treatment of Infections
Center For Sight of Northwest Florida, PA
Cesar L. Llaner, MD
Charles D. Stavely, MD
Cheryl S. Jones, MD
Child Neurology Center of NW FL
• Weldon A. Mauney, MD
• Sara A. Winchester, MD
Children's Clinic of Pensacola, PA
Clearway Pain Solutions Inst.
Coastal Foot and Ankle Clinic
Coastal Orthopaedic Trauma LLC
Coastal Podiatry
Coastal Skin Surgery & Dermatology
Coastal Urology, PA

Exhibit B

Sacred Heart Health System, Inc.
d/b/a Ascension Sacred Heart
d/b/a Ascension Sacred Heart Pensacola
d/b/a Ascension Sacred Heart Emerald Coast
d/b/a Ascension Sacred Heart Gulf
Bay County Health System, LLC
d/b/a Ascension Sacred Heart Bay

AMOUNT GENERALLY BILLED CALCULATION

7/1/24

Sacred Heart Health System, Inc. d/b/a Ascension Sacred Heart ("Ascension Sacred Heart") calculates two AGB percentages – one for hospital facility charges and one for professional fees – both using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with IRS Reg. Sec. 1.501(r)-5(b)(3), 1.501(r)-5(b)(3)(ii)(B) and 1.501(r)-5(b)(3)(iii). The details of those calculations and AGB percentages are described below.

The AGB percentages for Ascension Sacred Heart are as follows:

AGB for hospital facility charges:

Ascension Sacred Heart Pensacola	25%
Ascension Sacred Heart Emerald Coast	21%
Ascension Sacred Heart Gulf	23%
Ascension Sacred Heart Bay	19%

AGB for physicians' professional fees:

Sacred Heart Medical Group	49%

These AGB percentages are calculated by dividing the sum of the amounts of all of the hospital facility's claims for emergency and other medically necessary care that have been allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility (separately for facility charges and professional services) by the sum of the associated gross charges for those claims. The only claims that are utilized for purposes of determining the AGB are those that were allowed by a health insurer during the 12-month period prior to the AGB calculation (rather than those claims that relate to care provided during the prior 12 months).

Notwithstanding the foregoing AGB calculations, Ascension Sacred Heart has chosen to apply a lower AGB percentage for Sacred Heart Medical Group as follows:

Sacred Heart Medical Group AGB:	25%

Exhibit C

Sacred Heart Health System, Inc.
d/b/a Ascension Sacred Heart
d/b/a Ascension Sacred Heart Pensacola
d/b/a Ascension Sacred Heart Emerald Coast
d/b/a Ascension Sacred Heart Gulf
Bay County Health System, LLC
d/b/a Ascension Sacred Heart Bay

Summary of Financial Assistance Policy

Sacred Heart Health System, Inc. d/b/a Ascension Sacred Heart ("Ascension Sacred Heart"), including the health ministries listed above, have a commitment to and respect for each person's dignity with a special concern for those who struggle with barriers to access healthcare services. Ascension Sacred Heart has an equal commitment to manage its healthcare resources as a service to the entire community. In furtherance of these principles, Ascension Sacred Heart provides financial assistance for certain individuals who receive emergency or other medically necessary care from Ascension Sacred Heart. This summary provides a brief overview of Ascension Sacred Heart's Financial Assistance Policy.

Who Is Eligible?

You may be able to get financial assistance if you live in Sacred Heart Health System, Inc., d/b/a, Ascension Sacred Heart Pensacola, d/b/a Ascension Sacred Heart Emerald Coast, d/b/a Ascension Sacred Heart on the Gulf, and Bay County Health System, LLC d/b/a Ascension Sacred Heart Bay. Financial assistance is generally determined by your total household income as compared to the Federal Poverty Level. If your income is less than or equal to 250[5]% of the Federal Poverty Level, you may receive a 100% charity care write-off on the portion of the charges for which you are responsible. If your income is above 250[13]% of the Federal Poverty Level but does not exceed 400[6]% of the Federal Poverty Level, you may receive discounted rates on a sliding scale. If you have medical debt for emergency and medically necessary care that exceeds your income, you may be eligible for a discount. If you have assets in excess of 250% of your Federal Poverty Level income amount you may not qualify for financial assistance. Patients who are eligible for financial assistance will not be charged more for eligible care than the amounts generally billed to patients with insurance coverage.

What Services Are Covered?

The Financial Assistance Policy applies to emergency and other medically necessary care. These terms are defined in the Financial Assistance Policy. All other care is not covered by the Financial Assistance Policy.

How Can I Apply?

To apply for financial assistance, you typically will complete a written application and provide supporting documentation, as described in the Financial Assistance Policy and the Financial Assistance Policy application.[7]

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[5] Percentage should be the same as set in the FAP. As noted in the FAP, Health Ministries may adjust the 250% threshold higher, but not lower, for cost of living utilizing the local wage index compared to national wage index.
[6] Percentage should be the same as set in the FAP. As noted in the FAP, Health Ministries may adjust the 400% threshold higher or lower for cost of living utilizing the local wage index compared to national wage index.
[7] The FAP allows the Health Ministry to define its process for applying for financial assistance. The Organization should add to this section of the Summary pertinent details specific to the Organization's application process.

Exhibit C

How Can I Get Help with an Application?
For help with a Financial Assistance Policy application, you may contact Ascension Sacred Heart by phone at 1-866-869-9677

How Can I Get More Information?
Copies of the FAP and FAP application form are available at https://healthcare.ascension.org/Billing/Florida/FLPEN and at all patient registration departments. Free copies of the FAP, FAP application and information also can be obtained by mail by calling Customer Service toll free @ 1-866-869-9677.

What If I Am Not Eligible?
If you do not qualify for financial assistance under the Financial Assistance Policy, you may qualify for other types of assistance. For more information, please contact Customer Service toll free @ 1-866-869-9677.

Translations of the Financial Assistance Policy, the Financial Assistance Policy application and instructions, and this plain language summary are available in the following languages on our website and upon request: Spanish

[Form of FAP Application and Instructions Follow Starting on the Next Page]

Financial assistance application form

Ascension

Patient information

(Please print and all fields must be completed. Indicate N/A if not applicable on any individual line in the application)

Date_____ Account number _____

Name (first and last)_____

Birth date_____ Marital status_____ Phone number _____

Mailing address_____ City_____ State_____ ZIP_____

Social security number (optional) _____

Employer_____ Employment status_____

Number of hours worked per week_____ Employer phone number_____

Responsible party's information/legal guardian's information

(If patient above is same as responsible party, leave this section blank.)

Name (first and last)_____

Birth date_____ Marital status_____ Phone number _____

Mailing address_____ City_____ State_____ ZIP_____

Social security number (optional) _____

Employer_____ Employment status_____

Number of hours worked per week_____ Employer phone number_____

Responsible party spouse information

(If patient is same as responsible party, fill in spouse information for patient.)

Name (first and last)_____

Birth date_____ Marital status_____ Phone number _____

Mailing address_____ City_____ State_____ ZIP_____

Social security number (optional) _____

Employer_____ Employment status_____

Number of hours worked per week_____ Employer phone number_____

Dependents of responsible party

(If patient is same as responsible party, fill in spouse information for patient.)

Name_____ Birth date_____ Relationship to responsible party _____

Name_____ Birth date_____ Relationship to responsible party _____

Name_____ Birth date_____ Relationship to responsible party _____

Name_____ Birth date_____ Relationship to responsible party _____

Number of adults and children living in household _____

Monthly income

(Fill in dollar amounts for each item listed below. Provide amount per month for each.)

Applicant earned income _____
Applicant spouse income _____
Social Security benefits _____
Pension/retirement income _____
Disability Income _____
Unemployment Compensation _____
Worker's compensation _____
Interest/dividend income _____

Child support received _____
Alimony received _____
Rental property income _____
Food Stamps _____
Trust fund distribution received _____
Other Income _____
Other Income _____
Total **gross monthly income $** _____

Monthly living expenses

Mortgage/rent _____
Utilities _____
Phone (landline) _____
Cell phone _____
Groceries/food _____
Cable/internet/satellite tv _____
Car payment _____
Child care _____

Child support/alimony _____
Credit cards _____
Doctor/hospital bills _____
Car/auto insurance _____
Home/property insurance _____
Medical/health insurance _____
Life insurance _____
Other monthly expense _____
Total monthly expenses $ _____

Assets

Cash/savings/checking accounts _____
Stocks/bonds/investments/CD(s) _____
Other real estate/secondary residence _____
Boat/RV/motorcycle/recreational vehicle _____
Collector automobiles/non-essential automobiles
_____
Other assets _____

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.

Signature of Applicant _____

Date _____

Comments _____

Ascension

Letter of support

Patient medical record number/account number_____

Supporter's name_____

Relationship to patient/applicant _____

Supporter's address _____

To Ascension:

This letter is to advise that (patient's name)_____ receives little to no income and I am assisting with his/her living expenses. He/She has little to no obligation to me.

By signing this statement, I agree that the information given is true to the best of my knowledge.

Signature of supporter_____

Date _____

Ascension

[Date]

Dear Patient/Applicant,

Ascension is driven by compassion and dedicated to providing personalized care for all—especially those most in need. It is our mission and privilege to offer financial assistance to our patients. Financial assistance is available only for emergency and other medically necessary care. Thank you for trusting us to care for you and your family for all of your healthcare needs.

We are sending this letter and the attached financial assistance application because we received your request. If you did not request this, please disregard. Please complete both sides, including your signature and date before returning it. If you completed an application within the past six months and were approved for financial assistance, please notify us. You may not need to complete a new application. We will not consider a prior application that is greater than six months old.

Along with the application, please provide a copy of the following items as your proof of income. If you are married or have lived with a significant other for 6 months or longer, they will also need to provide a copy of at least one of the following items as proof of their income before the application can be processed.

- Copies of 3 most recent paystubs from employer
- Copies of most recent yearly tax return (if self-employed, include all schedules)
- Social Security and/or Pension Retirement Award Letter
- Parent or Guardian's most recent yearly tax return, if applicant is a dependent listed on their tax form and under the age 25
- Other income validation documents
- Copies of bank statements from last 3 months
- Copy of receipt of unemployment benefits

If you receive assistance from or live in a home with a family or friends, please have them complete the attached form labeled "Letter of Support." This will not make them responsible for your medical bills. This will help show how you are able to afford living expenses. If you receive no assistance from family and friends, you do not need to fill out the Letter of Support form.

Please know that the completed application along with proof of income must be received in order for the application to be considered. We are unable to process or consider applications that are not complete.

Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email may be intercepted and read by other parties besides the person to whom it is addressed.

We want to protect your personal information and ensure that it remains secure. Since the application contains your social security number and other private information, we urge you to refrain from emailing it.

Please print and mail or your completed application to the following address:

[STREET]
[SUITE]
[CITY, STATE ZIP]

If you have any questions about this application, please call one of our Patient Representatives at xxx-xxx-xxxx.

Sincerely,

Patient Financial Services
Ascension