



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. Unfortunately, we are unable to rely on a prior application that is greater than six months old.

Along with the application, you will need to provide verification of your household's income and verification of all assets owned by any household member.

Examples of proof of income and assets include:

- 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
- Copy of receipt of unemployment benefits
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance
- Other income validation documents

Examples of proof of assets include:

- Current bank statements (checking and savings accounts) from last 3 months
- Investments, including stocks and bonds
- Trust funds
- Money market accounts
- Mutual funds

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 do not receive assistance from family and friends, you do not need to fill out the Letter of Support form.

Finally, we may be able to consider your outstanding medical bills to qualify you for financial assistance. If you would like for us to consider this, please also provide documentation of your outstanding monthly medical and pharmacy/drug costs, such as current invoices or statements of account balances. **Please know that the 1) completed application along with 2) proof of income, 3) assets, and 4) outstanding medical bills (if applicable) must be received in order for the application to be considered. We are unable to process or consider applications that are not complete.**

When submitting your application, please keep in mind that communications via email over the internet are not secure. Although it may be 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 mail or fax your application to the appropriate location. For the phone number of your provider or fax/ mailing address where applications should be submitted, please refer to the next page of the application.

Sincerely,

Patient Financial Services
Ascension



Ascension Saint Thomas

Provider Name	Phone Number	Address	Fax Number	Email Address
Ascension Saint Thomas West	(800)-242-7416	Ascension St. Thomas Financial Assistance Team PO Box 504475 St. Louis, MO 63150-0001	(629)204-6542	
Ascension Saint Thomas Midtown	(800)-242-7416	Ascension St. Thomas Midtown Financial Asst. Team PO Box 504475 St. Louis, MO 63150-0001	(629)204-6540	
Ascension Saint Thomas Rutherford	(800)-242-7416	Ascension St. Thomas Rutherford Financial Asst. Team PO Box 504475 St. Louis, MO 63150-0001	(629)204-6541	
Ascension Medical Group Financial Assistance	(833)263-9791	STHe Financial Asst. PO Box 80278 Indianapolis, IN 46240	(317)981-6312	AscensionFinancialCounselors@r1rcm.com
Ascension Saint Thomas Highlands	(877)348-7082	Ascension St. Thomas Highlands Financial Asst. Team PO Box 504475 St. Louis, MO 63150-0001	(931)738-2669	
Ascension Saint Thomas Dekalb	(877)348-7082	Ascension St. Thomas Dekalb Financial Asst. Team PO Box 504475 St. Louis, MO 63150-0001	(931)738-2669	
Ascension Saint Thomas River Park	(877)348-7082	Ascension St. Thomas River Park Financial Asst. Team PO Box 504475 St. Louis, MO 63150-0001	(931)738-2669	
Ascension Saint Thomas Three Rivers	(931)296-0266	Ascension St. Thomas Three Rivers Financial Asst. Team 451 Hwy 13 S. Waverly, TN 37185	(931)296-4561	
Ascension Saint Thomas Stones River	(877)348-7082	Ascension St. Thomas Stones River Financial Asst. Team PO Box 504475 St. Louis, MO 63150-0001	(931)738-2669	
Ascension Saint Thomas Hickman	(931)729-6800	Ascension St. Thomas Hickman 135 E. Swan Street Centerville, TN 37033	(931)729-0174	
Ascension Saint Thomas Lab Plus	(615)284-2773	Lab Plus LLC Attn: Billing Dept 2000 Church Street Nashville, TN 37236	(615)284-2771	
Ascension Saint Thomas Center for Speciality Surgery	(615)341-7500	STHe Financial Asst. 2011 Murphy Ave, Ste 400 Nashville, TN 37203	(615)341-7513	
Saint Thomas EMS	(877)664-4076	STHe Financial Assistance PO Box 681787 Franklin, TN 37064	(615)236-4040	
Baptist Ambulatory Surgical Center	(615)321-7330	STHe Financial Asst. 312 21st Ave. North Nashville, TN 37203	(615)320-5319	
Ascension Saint Thomas Center for Sleep	(615)222-6638	STHe Financial Asst. PO Box 380 Nashville, TN 37202		



Ascension Saint Thomas Financial Assistance Application Form

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 _____	Child support received _____
Applicant spouse income _____	Alimony received _____
Social security benefits _____	Rental property income _____
Pension/retirement income _____	Food stamps _____
Disability income _____	Trust fund distribution received _____
Unemployment compensation _____	Other income _____
Worker's compensation _____	Other income _____
Interest/dividend income _____	Total gross monthly income \$ _____

Monthly living expenses

Mortgage/rent _____	Child support/alimony _____
Utilities _____	Credit cards _____
Phone (landline) _____	Doctor/hospital bills _____
Cell phone _____	Car/auto insurance _____
Groceries/food _____	Home/property insurance _____
Cable/internet/satellite tv _____	Medical/health insurance _____
Car payment _____	Life insurance _____
Child care _____	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 _____

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 _____