

Financial Assistance Application

St. Alphonus has financial assistance available to all patients who qualify. Please understand that if you qualify for financial assistance it does not mean all accounts or future accounts will qualify for the same assistance. All financial resources such as: personal insurance, Medicare, Medicaid, County Assistance, etc. must be exhausted before financial assistance will be considered.

If you and/or a family member have applied for financial assistance at St Alphonus Regional Medical Center or any St Alphonus Physician Office within the last six months, please call us at 208-367-2130 before completing this application.

St. Alphonus will need one or more of the following documents to review and complete the application process. If this information is not attached the financial assistance application may be denied.

- A recent pay stub for yourself and/or your spouse.
- A W2 or federal tax return for you and/or your spouse.
- Social security and/or social security disability for you and/or your spouse-
 - Award letter (copy), Check (copy), Bank statement-showing automatic deposit
- If self-employed, the most recent federal tax return and all schedules to include profit and loss statements.
- Unemployment statements.
- Physician note stating you and/or your spouse are unable to work.
- A letter from Social Security Disabilities stating a claim is being reviewed, denied or pending.
- Copy of school schedule for you and/or your spouse.
- Any other documentation showing income.
- A letter from family or friends if you are receiving financial help with monthly expenses, such as rent, utilities, etc.
- Food stamp documentation.
- A letter from a halfway house, shelter, or Vocational Rehab, if applicable.

Thank you for your cooperation in this important matter.

Please return the financial assistance application and proof-of-income to:

**St Alphonus RMC Patient Accounts
PO Box 190930
Boise ID 83719-9919**

Return by _____

Please allow approximately 30-45 days for the application to be processed. If you have any questions, please feel free to contact our **Customer Service Department at 208-367-2130.**

MONTHLY HOUSEHOLD LIABILITIES/EXPENSES	Balances	Monthly Payment
Rent/Mortgage per Month.....	\$ _____	\$ _____
Car Loan Payments Per Month.....	\$ _____	\$ _____
Loan/Student Loan Payments Per Month.....	\$ _____	\$ _____
Credit Card Payments per Month.....	\$ _____	\$ _____
Utilities (Power, Gas, Water, Sewer, Trash)	_____	\$ _____
Cable/Internet.....	_____	\$ _____
Phone/Cell Phone	_____	\$ _____
Daycare and/or Child Support.....	_____	\$ _____
Grocery Expense.....	_____	\$ _____
Vehicle Insurance	_____	\$ _____
Fuel	_____	\$ _____
Health Insurance	_____	\$ _____
Medication Expenses per Month.....	_____	\$ _____
Any other monthly expenses	_____	\$ _____
Total Medical payments per Month to other doctors, medical facilities, and/or dental.....	_____	\$ _____
TOTAL MONTHLY PAYMENTS		\$ _____

OTHER INFORMATION WE SHOULD KNOW TO ASSIST IN OUR UNDERSTANDING OF YOUR FINANCIAL SITUATION. IF YOU HAVE NO MONTHLY INCOME, PLEASE TELL US ABOUT YOUR SITUATION:

If we need additional information, you will be notified by telephone, US Mail or e-mail.

- I certify that all information 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 authorize Saint Alphonus Regional Medical Center to obtain a credit report and to verify banking information and employment information.
- I authorize the release of any and all information from the Idaho Division of Family and Children's Services.
- **I understand that I must provide verification of income, expenses, dependents, bank statements, pay vouchers and tax statements if applicable.**
- I also understand that I will be liable for full payment of any services rendered at Saint Alphonus Regional Medical Center if the above information is given under false pretenses.
- I know that I am asking for financial assistance from Saint Alphonus Regional Medical Center only and not from other health care providers or physicians.

Signature _____

Date _____

For Hospital Use Only:

Application Received: _____

Application Expires: _____

Charity % Approved: _____

Charity % Requested: _____

Extra Information requested: _____

Need by: _____

Information Received: _____