

Financial Assistance Application

In order for St. Alphonus to process any financial assistance application, **one of the following documents needs to be sent with the form**; otherwise the financial assistance application may not be processed. **Also, please include a list or copy of all medical debt excluding St. Alphonus Regional Medical Center.**

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

- 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.
- Unemployment statements.
- Physician note stating you and/or your spouse are unable to work.
- Copy of school schedule for you and/or your spouse.
- Any other documentation showing income.

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 a large balance the completion of this application may take longer due to processing thru management.

Please feel free to contact our **customer service at 208-367-2130** if you have any questions.

CONFIDENTIAL FINANCIAL EVALUATION

Have you and/or a family member applied for financial assistance at St Alphonus Regional Medical Center or any St Alphonus Physician Office within the last six months?

******* If so, please call us at 208-367-2130 before completing this application *******

1. **If you are applying for financial assistance, you must first exhaust other possible funding, such as Medicaid, County Indigent Assistance, Crime Victims, Workers' Compensation, COBRA or Auto/Home Owners Insurance.**
2. Answer each question and return this form within 10 days to Saint Alphonus Regional Medical Center, PO Box 190930, Boise, ID 83719. (Please call a Financial Advisor at 367-2130 if you need help with this form)
3. Attach one of the following for yourself and spouse/significant other: a recent copy of a wage stub, W2, SSI/SSD, Unemployment or any other documentation showing income.
4. If Self-employed, attach your latest Federal Tax Return, **all** Schedules and three (3) months of bank statements showing all deposits.
5. We cannot complete your application for SARMC financial assistance if we do not have all of the information required, including wage verification.
6. If you have no income, please provide an explanation of how your living expenses (Housing, Food, Utilities, etc.) are paid.
7. If we need additional information, you will be notified by telephone, US Mail or e-mail.

Patient Name: _____ Account #: _____ Account Balance _____
 Date of Birth: _____ Social Security Number: _____ E-mail: _____
 Address: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____

Do you have Insurance? No ___ Yes___ Do you have Medicaid? No ___ Yes___ Do you have Medicare? No ___ Yes ___

Please provide the following information for the individual responsible for payment

Name: _____ Date of Birth: _____ Social Security #: _____
 Address (if Different) _____ Telephone: _____
 _____ Social Security Number: _____

Please provide the following for all household additional members (Attach Additional sheet if necessary)

Name	Date of Birth	Relationship to Patient	Social Security Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HOUSEHOLD INCOME FROM EMPLOYERS

Person Employed	Employer	Hourly Wage	Hours/Week	Monthly Total
_____	_____	\$ _____	_____	\$ _____
_____	_____	\$ _____	_____	\$ _____
_____	_____	\$ _____	_____	\$ _____

Are you a student? (Y / N)...If yes, does the school require you to carry health insurance? (Y / N)

Name of School _____ **(Please attach copy of school schedule)**

HOUSEHOLD INCOME FROM OTHER SOURCES

Child Support / Alimony Received.....	\$ _____
Food Stamps / Foster Care.....	\$ _____
Pension / Social Security / Social Security Disability.....	\$ _____
Rental Property.....	\$ _____
Stocks, Bonds, Annuities, Interest.....	\$ _____
Unemployment or Worker's Compensation.....	\$ _____
Other Income.....	\$ _____
TOTAL MONTHLY INCOME	\$ _____

