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|  **Please complete and sign application form and return within 10 days including copies of the following:** |
|  Required Verifications  [ ]  Past One month Proof of Gross Income  [ ]  Past Two months Complete Bank Statements for all bank accounts, with all pages included. (Explanation for recurring deposits) [ ]  Recent Tax Returns (1040 form with Schedule C, E or F) or Three Months Profit and Loss Statements (for self-employed/dependents) Provide the following, If applicable [ ]  Recent W2 for Seasonal Income [ ]  Unemployment Benefit/ Denial letter [ ]  Child Support Income /Alimony  [ ]  No Income – Complete Letter of Financial Support portion of the application |

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| **Patient Information**  |
| Patient Name  | Date of Birth |
| Social Security/EIN Number (optional)] | Mobile Phone | Other Phone |
| Mailing Address | City | State | Zip code |
| Email Address | What state are you a resident? |
| Marital status □ Single □ Married □ Divorced □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Do you file a Federal Tax Return? □ Yes □ No If no, why? | Can you be claimed as dependent on someone else's tax return? □ Yes □ No |
| Did you or your dependents have health insurance coverage at the time of service? □ Yes □ No (Provide Insurance card copy) |
| Are you a documented resident of the United States? □ Yes □ No □ Prefer Not to Answer |
| Household Members, including yourself based on your recent Tax Returns | Date of Birth | Relationship to Patient | Claimed on Tax Return (Yes/No) |
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| **Income Verification for all household members** |
| Monthly Income Source | Who receives this? | Gross Monthly Income (before taxes) | Monthly Income Source | Who receives this? | Gross Monthly Income (before taxes) |
| Wages |  |  | Worker’s Compensation |  |  |
| Social Security / Disability |  |  | Unemployment |  |  |
| Pension |  |  | Child Support / Alimony |  |  |
| Self-Employment |  |  | Rental Land Income |  |  |
| Public Assistance |  |  | Other |  |  |
| **Letter of Financial Support - Should only be completed by the person providing support** |
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|[ ]  I provide more than 50% support for the patient's living expenses, but I am unable to help with medical bills. |
|[ ]  By signing this letter, I verify that the above statement is correct and that I will in no way be held liable for the patient's bills. If you have questions, please contact me at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Phone Number) |
| **Name of person providing support** | **Relationship to Patient** |
| **Signature of person providing support** |  **Date** |

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**Verification of Income and Identification**

I certify that the information listed in this application is true and complete to the best of my knowledge. I understand that the information provided is subject to verification. I will be responsible for repayment of any services provided at Trinity Health affiliates if the above information is provided under false pretenses.]

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Or Signature of Legal Guardian (If Applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please mail your application to the address above, fax at 312-871-3350 and or upload documents through MyChart (Patient Portal) -** [**https://mychart.trinity-health.org/MyChart**](https://mychart.trinity-health.org/MyChart) **If you have any questions, please contact our Customer Service Center at 800-494-5797 Monday through Friday 9 a.m. - 5 p.m. ET.**