Financial Assistance Application

Patient Account Number(s)

List hospital(s) you were treated

Patient Last Name

Patient First Name

Patient Social Security #

Patient Date of Birth

Guarantor Last Name (If Different)

First Name

Guarantor Social Security #

Date of Birth

Guarantor Home Address

Home Telephone Number

City

State

Zip Code

Guarantor's Employer Name

Guarantor Job Function/Department

Guarantor's Employer Address

Guarantor's Employer Telephone

City

State

Zip Code

Spouse's Employer Name

Spouse's Job Function/Department

Spouse's Employer Address

Spouse's Employer Telephone

City

State

Zip Code

People in household (including applicant)

Name	Relationship to Patient	Date of Birth	Employer	Annual Income
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

Revised November 16/2016

Dignity Health Financial Assistance Application (Continued)

In order to determine who truly qualifies for financial assistance, we must first require submission of the information listed below to demonstrate financial hardship. Please complete the application and return it with all the following items listed below. If you are unable to supply one of the documents or there are additional factors that may influence the evaluation, please submit a written statement explaining your situation.

Documentation Required:

1. Proof of Identity - **One** of the following:
   - Copy of Social Security Card
   - Copy of state issued driver's license
   - Copy of other photo ID

2. Verification of Current Address - **One** of the following:
   - Rent receipt
   - Utility Bill

3. Denial of eligibility from Medicaid program from state of residence.

4. Proof of income for all family members* in the 12 months prior to the date on which Dignity Health services were provided. This could include the most current Income Tax Return(s) or pay stubs for the same time period. If self-employed, include Schedule C with your Tax Return. If these are unavailable, please write an explanation on a separate piece of paper, stating your financial situation over the last three months, and submit it with this application.

*A Patient's Family includes:

a) For persons 18 years of age and older, a spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not.
b) For persons under 18 years of age, a parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

Once we have completed our initial review of the documents provided, the following may be required to determine qualification:

Proof of Monetary Assets - **All** of the following:

- Checking account statements-last 3 months
- Savings account statements-last 3 months
- Stocks, Bonds, & CD's

By signing below you agree to be considered for Payment Assistance. Additionally, you certify that all the statements made on this application are true and complete to the best of your knowledge. Should it be determined that the information you provided is incomplete or false, any discount on your bill may be reversed and payment in full may be expected from you. By signing below, you authorize Dignity Health to check references and credit history in order to evaluate this application for financial assistance consideration.

If you receive payment from an insurance company, workers compensation plan, or any other third party, you agree to inform Dignity Health of any such payment. Dignity Health retains its right to collect the original, full billed charges should a third party provide you with payment for the hospital's services.

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Signature of person responsible for bill (Guarantor) Date

Dignity Health Medical Group

Return completed application to:

Email: pbscustomerservice@dignityhealth.org
Fax: 602-798-9448

Or by mail to:
Physicians Billing Service
Attention: Financial Assistance, Customer Service
P.O. Box 33269
Phoenix, AZ 85067

FOR OFFICE USE ONLY

___________________________________ ___________________________________

Date received by PBS Customer Service **Received by:**