



To Our Valued Patient:

Thank you for choosing CHRISTUS St. Vincent Regional Medical Center for your healthcare needs. Enclosed you will find an application for hospital financial assistance and hardship adjustments. Please return the completed application and provide all supporting documentation to the hospital business office.

Patients with a family income at or below 400% of the applicable federal poverty guideline who lack sufficient funds to pay their bills may be eligible for assistance. Patients with significant medical bills regardless of income may also be eligible for assistance. In addition to partial or full adjustments, CHRISTUS St. Vincent also offers payment plan arrangements.

We understand your desire for privacy. Accordingly, except for verification purposes, the information included in your application will be treated as confidential. It will only be shared within CHRISTUS St. Vincent on a need to know basis.

Upon receipt of a completed application, our staff will conduct a review of the application for possible assistance towards the balance on your account(s) with CHRISTUS St. Vincent. We will notify you of your eligibility for assistance or adjustments within 30 days of receiving your completed application.

Again, we would like to thank you for choosing CHRISTUS St. Vincent for your health care needs. If you have any questions or need help completing the application, please contact a hospital financial counselor or call the number listed below.

Sincerely,

CHRISTUS St. Vincent Regional Medical Center
505-913-5220
Monday – Friday
8:00 AM to 5:00 PM (mountain)

Please send completed applications to:
CHRISTUS St. Vincent Regional Medical Center
Attn: Financial Counselors
455 St. Michael's Drive
Santa Fe, NM 87505
Or deliver in person to the hospital admitting department

Application Date: _____ Guarantor Name (if not patient): _____

Patient Name: _____ Date(s) of Service: _____

Hospital Account # _____ Medical Record # _____

Patient(s) Name: _____ Account #: _____

Does the patient have health insurance? Yes No If yes, please name the insurance provider: _____
If the patient has insurance coverage, you are not eligible for financial assistance but you may be eligible for hardship adjustments. If you need help paying your deductible, co-insurance, or co-pay, please complete this application.

If the patient does not have insurance, you may be eligible for financial assistance. Please complete this application.

YOU MUST PROVIDE AT LEAST 2 OF THE FOLLOWING:

- ___ Most recent and complete Income Tax Return
- ___ 3 most recent pay check stubs
- ___ 3 most recent checking/savings account statements
- ___ Food Stamp or SSI/SSA/SSD award letter

YOU MUST PROVIDE PROOF OF IDENTITY WITH AT LEAST 1 THE FOLLOWING:

- ___ Current Driver's License ___ Alien Registration
- ___ Passport ___ State-Issued Identification Card

PERSONAL DATA:

RESPONSIBLE PERSON

SPOUSE

Name	_____	_____
Social Security #	_____	_____
Date of Birth	_____	_____
Street Address/Apt. #	_____	_____
City, State, Zip	_____	_____
Phone #	_____	_____

EMPLOYMENT DATA:

Employer Name	_____	_____
Explain, if self-employed	_____	_____
Address	_____	_____
Phone #	_____	_____
# of Hours Worked/Week	_____	_____
Job Title	_____	_____
Length of Employment	Yrs _____ Months _____	Yrs _____ Months _____
Gross Monthly Salary	_____	_____

** If you report \$0 income, please attach a brief statement of how you or the patient are meeting basic needs.

OTHER HOUSEHOLD MEMBERS:

Name	_____	Age	_____	DOB	_____	Relationship	_____
Name	_____	Age	_____	DOB	_____	Relationship	_____
Name	_____	Age	_____	DOB	_____	Relationship	_____
Gross Monthly Salary	_____						

ADDITIONAL INCOME:

2nd Job: N Y: \$ _____/month
 Small Business: N Y: \$ _____/month
 Other: (ex. investments, savings, child support, other governmental aid) \$ _____/month

DEBT:

Home Mortgage: \$ _____/month
 (Unpaid Balance \$ _____)
 Credit Card Debt: \$ _____
 Automobile/Boat/RV etc: \$ _____/month

OTHER EXPENSES:

Medical Bills: \$ _____/month
 Pharmacy Bills: \$ _____/month
 Other: (ex. loans, rent, cable, gas phone, utilities, food) \$ _____/month

Are any third parties potentially liable for your medical expenses (i.e. auto insurance, workers' compensation, lawsuit)? Yes No

List personal assets, including cars (excluding one car per driver), cash/savings, non-retirement stock holdings or bonds, and second homes or other real estate: _____

I certify that I am unable to pay for all the costs of necessary services and that the information I have given to CHRISTUS St. Vincent is true and accurate. I understand that CHRISTUS St. Vincent will use this information to determine my eligibility for assistance and adjustments. I understand that CHRISTUS St. Vincent may ask me questions about the information I have provided. I have disclosed all my assets and income. Failure to report assets or income could result in legal recourse, including criminal charges. I agree to report any changes in my financial status to CHRISTUS St. Vincent. I authorize CHRISTUS St. Vincent, or any credit reporting agency, to investigate statements, employment, or other data given by me or any other person pertaining to my credit and financial responsibility.

Patient/Guarantor Signature _____ Date _____

Spouse's Signature _____ Date _____