To Our Valued Patient:

Thank you for choosing CHRISTUS Health for your healthcare needs. Enclosed you will find an application for hospital financial assistance. This is for your hospital charges only. 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, assistance includes extended payment 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 Health 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 Health. We will notify you in writing after our review.

Again, we would like to thank you for choosing CHRISTUS Health for your health care needs. If you have any questions regarding the application or the above information, please contact a hospital financial counselor or call the number listed below.

Sincerely,

CHRISTUS Health
800-756-7999
Monday – Friday
8:00 AM to 5:00 PM (central)
CHRISTUS Health Trinity Mother Frances Patients, mail application to:
CHRISTUS Health
Attn: Financial Assistance
PO Box 6997
Tyler TX 75711

Application Date: ___________________  Guarantor Name (if not patient): ________________________________________

Patient Name: ____________________________________  Date(s) of Service: _____________________

Hospital Account #_________________________________  Medical Record # _____________________

® CHRISTUS St. Michael Hospital
® CHRISTUS St. Michael Hospital – Atlanta
® CHRISTUS St. Michael Hospital- Rehab
® CHRISTUS St. Frances Cabrini Hospital
® CHRISTUS Cushing Health Care Center
® CHRISTUS Highland Medical Center
® CHRISTUS Bossier Emergency Hospital
® CHRISTUS St. Patrick Hospital
® CHRISTUS Ocshner Lake Area Medical Ctr
® CHRISTUS Hospital – St. Elizabeth
® CHRISTUS Hospital – St. Mary
® CHRISTUS Jasper Memorial Hospital
® Kate Dishman Rehabilitation Hospital
® CHRISTUS St. Vincent Regional Medical Ctr
® CHRISTUS Good Shepherd Longview
® CHRISTUS Good Shepherd Marshall
® CHRISTUS Trinity Mother Frances- Tyler
® CHRISTUS Trinity Mother Frances- Winnsboro
® Children’s Hospital of San Antonio
® CHRISTUS Santa Rosa Hospital – Medical Center
® CHRISTUS Santa Rosa Hospital – Westover Hills
® CHRISTUS Santa Rosa Hospital – New Braunfels
® CHRISTUS Santa Rosa Hospital – Alamo Heights
® CHRISTUS Santa Rosa Hospital – Alon
® CHRISTUS Santa Rosa Hospital – Creekside
® CHRISTUS Santa Rosa Hospital – San Marcos
® CHRISTUS Spohn Hospital – Shoreline
® CHRISTUS Spohn Hospital – South
® CHRISTUS Spohn Hospital – Memorial
® CHRISTUS Spohn Hospital – Kleberg
® CHRISTUS Spohn Hospital – Alice
® CHRISTUS Spohn Hospital – Beeville
® CHRISTUS Trinity Mother Frances- Sulphur Springs
® CHRISTUS Trinity Mother Frances- Jacksonville
® CHRISTUS Trinity Mother Frances- South Tyler
® CHRISTUS Trinity Mother Frances- Rehabilitation
FINANCIAL ASSISTANCE APPLICATION

Patient(s) Name: ___________________ _______________________________ Account #: _____________________

YOU MUST PROVIDE AT LEAST 1 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
- If you report a $0 income, please attach a brief explanation of how you or the patient are meeting basic needs

YOU MUST PROVIDE PROOF OF IDENTITY WITH AT LEAST 1 THE FOLLOWING:
- Current Driver’s License
- Alien Registration

PERSONAL DATA:

<table>
<thead>
<tr>
<th>RESPONSIBLE PERSON</th>
<th>SPOUSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Social Security #</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Street Address/Apt. #</td>
<td></td>
</tr>
<tr>
<td>City, State, Zip</td>
<td></td>
</tr>
<tr>
<td>Home Phone #</td>
<td></td>
</tr>
</tbody>
</table>

EMPLOYMENT DATA:

<table>
<thead>
<tr>
<th>Employer Name</th>
<th>Address</th>
<th>Phone #</th>
<th># of Hours Worked/Week</th>
<th>Job Title</th>
<th>Length of Employment</th>
<th>Gross Monthly Salary</th>
</tr>
</thead>
</table>

OTHER HOUSEHOLD MEMBERS:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>DOB</th>
<th>Relationship</th>
</tr>
</thead>
</table>

ADDITIONAL INCOME:

<table>
<thead>
<tr>
<th>2nd Job: N Y: $_____ /month</th>
<th>Home Mortgage: $_______ /month</th>
<th>Medical Bills: $_______ /month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small Business: N Y: $_______ /month</td>
<td>Held by:________________________</td>
<td>Pharmacy Bills: $_______ /month</td>
</tr>
<tr>
<td>Other: (ex. investments, savings, child support, other governmental aid) $_______ /month</td>
<td>Unpaid Balance: $_______</td>
<td>Other: (ex. loans, rent, cable, gas phone, utilities, food) $_______ /month</td>
</tr>
</tbody>
</table>

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

I certify that I am unable to pay for all the costs of necessary services and that the information I have given to CHRISTUS Health is true and accurate. I understand that CHRISTUS Health will use this information to determine my eligibility for financial assistance. 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 Health. I authorize CHRISTUS Health, or any credit reporting agency, to investigate any reference, 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 ______________________