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

All Other CHRISTUS Health Patients mail application to:
CHRISTUS Health
Attn: Financial Assistance
2707 North Loop West
Suite 400
Houston, TX 77008

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 Coushatta 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 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

CHRISTUS Health

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
__ Passport __State-Issued Identification Card

PERSONAL DATA:	***RESPONSIBLE PERSON***	***SPOUSE***
Name	_____ _____	_____
Social Security #	_____	_____
Date of Birth	_____	_____
Street Address/Apt. #	_____	_____
City, State, Zip	_____	_____
Home 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	_____	_____

OTHER HOUSEHOLD MEMBERS:

Name _____ Age _____ _ DOB_____ Relationship _____
Name _____ Age _____ _ DOB_____ Relationship _____
Name _____ Age _____ _ DOB_____ Relationship _____
Gross Monthly Salary _____ _____

ADDITIONAL INCOME:	***DEBT:***	***OTHER EXPENSES:***
2nd Job: N Y: $_____/month	*Home Mortgage: $_____ /month*	*Medical Bills: $_____/month*
Small Business: N Y: $_____/month	*Held by:_____*	*Pharmacy Bills: $_____ /month*
Other: (ex. investments, savings, child support, other governmental aid) $_____/month	*Unpaid Balance: $_____* *Automobile/Boat/RV etc: $_____/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

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 _____