



To Our Valued Patient:

Thank you for choosing CHRISTUS Santa Rosa Hospital – Alamo Heights 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 Santa Rosa Hospital – Alamo Heights 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 Santa Rosa Hospital – Alamo Heights. We will notify you in writing after our review.

Again, we would like to thank you for choosing CHRISTUS Santa Rosa Hospital – Alamo Heights 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 Santa Rosa Hospital – Alamo Heights
210-294-8002
Monday – Friday
8:00 AM to 5:00 PM (central)

Please return completed applications to:

CHRISTUS Santa Rosa Hospital – Alamo Heights
Attn: Business Office
100 NE Loop 410, Suite 475
San Antonio, TX 78216-4749

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

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

Hospital Account # _____ Medical Record # _____

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: <input type="checkbox"/> N <input type="checkbox"/> Y: \$ _____/month	Home Mortgage: \$ _____/month	Medical Bills: \$ _____/month
Small Business: <input type="checkbox"/> N <input type="checkbox"/> Y: \$ _____/month	Held by: _____	Pharmacy Bills: \$ _____/month
Other: (ex. investments, savings, child support, other governmental aid) \$ _____/month	Unpaid Balance: \$ _____	Other: (ex. loans, rent, cable, gas phone, utilities, food) \$ _____/month
	Automobile/Boat/RV etc: \$ _____/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 _____