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)

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

Patient Name: _____________________________________ Date(s) of Service: ____________________________

Hospital Account #: ____________________________ Medical Record #: ____________________________

☐ CHRISTUS St. Michael Hospital ☐ Children’s Hospital of San Antonio
☐ CHRISTUS St. Michael Hospital – Atlanta ☐ CHRISTUS Santa Rosa Hospital – Medical Center
☐ CHRISTUS St. Frances Cabrini Hospital ☐ CHRISTUS Santa Rosa Hospital – Westover Hills
☐ CHRISTUS Coushatta Health Care Center ☐ CHRISTUS Santa Rosa Hospital – New Braunfels
☐ CHRISTUS Highland Medical Center ☐ CHRISTUS Spohn Hospital – Shoreline
☐ CHRISTUS Schumpert ☐ CHRISTUS Spohn Hospital – South
☐ CHRISTUS St. Patrick Hospital ☐ CHRISTUS Spohn Hospital – Memorial
☐ CHRISTUS Hospital – St. Elizabeth ☐ CHRISTUS Spohn Hospital – Kleberg
☐ CHRISTUS Hospital – St. Mary ☐ CHRISTUS Spohn Hospital – Alice
☐ CHRISTUS Jasper Memorial Hospital ☐ CHRISTUS Spohn Hospital – Beeville
☐ CHRISTUS St. Vincent Regional Medical Ctr ☐ CHRISTUS Trinity Mother Frances Health System
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

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:

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

DEBT:

Home Mortgage: $________/month Held by:______________________
Medical Bills: $________/month
Pharmacy Bills: $________/month
Unpaid Balance: $________
Automobile/Boat/RV etc: $________/month

OTHER EXPENSES:

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 ___________________________