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. 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 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 in writing after our review.

Again, we would like to thank you for choosing CHRISTUS St. Vincent 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 St. Vincent Regional Medical Center
505-913-5220
Monday – Friday
8:00 AM to 5:00 PM (mountain)

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

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

Hospital Account #__________________________________ Medical Record # ______________________

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CHRISTUS® ST. VINCENT
Regional Medical Center

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

YOU MUST PROVIDE PROOF OF IDENTITY WITH AT LEAST 1 THE FOLLOWING:
__ Current Driver's License __ Alien Registration
__ Passport __State-Issued Identification Card

__If you report a $0 income, please attach a brief explanation of how you or the patient are meeting basic needs

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:

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:______________________
Unpaid Balance: $________
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

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 ______________________