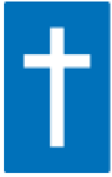

Dear Patient,

Thank you for choosing Saint Thomas Health for your healthcare needs. It is our mission and privilege to offer financial assistance to our patients.

At your request we have provided the attached financial assistance application. Please complete both sides, including your signature and date before returning it to the appropriate address, email, or fax number based on where services were provided.

Along with the application, please submit at least **one** of the following items as your proof of income. If you are married or have lived with a significant other for six (6) months or longer, proof of income will also be required from them before the application can be processed.

- Copies of your 3 most recent pay stubs showing total earnings (before taxes). **–OR-**

- Complete copy of your most recent tax return; if self-employed, please include **ALL** schedules. **–OR-**

- Copy of current Social Security, Pension/Retirement Award Letter OR Bank Statement showing Social Security, Pension/Retirement Deposit OR Copy of most recent Social Security, Pension/Retirement Check **–OR-**

- All students age 25 and younger must supply copies of their parent's most recent tax form if they were listed as a dependent on their parent's taxes. **–OR-**

- Other: If you receive assistance from or live in the home with family or friends please have them complete the attached form labeled "Letter of Support". This will NOT make them responsible for your medical bill. This is will only serve to show how you are able to afford living expenses If you receive no assistance the Letter of Support does not need to be completed.

The completed application along with proof of income must be received for consideration. Incomplete applications will not be processed.

For the phone number of your provider or address where applications should be submitted please refer to the reverse side of this page.

Sincerely,

Patient Financial Services
Saint Thomas Health

Saint Thomas Health

Provider Name	Phone Number	Address	Fax Number	Email Address
Saint Thomas West	(615) 222-6638	STHe Financial Asst. PO Box 380 Nashville, TN 37202	(615) 222-7700	
Saint Thomas Midtown	(615) 284-5340	STHe Financial Asst. PO Box 380 Nashville, TN 37202	(615) 222-7700	
Saint Thomas Rutherford	(615) 222-6638	STHe Financial Asst. PO Box 380 Nashville, TN 37202	(615) 222-7700	
Saint Thomas Medical Partners (Physicians)	(844) 686-2555	STHe Financial Asst. 10330 N. Meridian #200 Indianapolis, IN 46290	(317) 981-6312	
Saint Thomas Highlands	(877) 348-7082	STHe Financial Asst. 520 W Main St Smithville, TN 37166	(931) 738-2669	
Saint Thomas Dekalb	(877) 348-7082	STHe Financial Asst. 520 West Main Street Smithville, TN 37166	(931) 738-2669	
Saint Thomas River Park	(877) 348-7082	STHe Financial Asst. 520 W Main St Smithville, TN 37166	(931) 738-2669	
Saint Thomas Stones River	(877) 348-7082	STHe Financial Asst. 520 W Main St Smithville, TN 37166	(931) 738-2669	
Saint Thomas Hickman	(931) 729-6800	STHe Financial Asst. 135 E. Swan Street Centerville, TN 37033		
Lab Plus	(615) 284-2773	Lab Plus LLC Attn: Hilda Bishop 2000 Church Street Nashville, TN 37236		
Saint Thomas Center for Specialty Surgery	(615) 341-7500	STHe Financial Asst. 2011 Murphy Ave Suite 400 Nashville, TN 37203		STHSSFinAssist@uspi.com
Saint Thomas EMS	(877) 664-4076	STHe Financial Asst. PO Box 681787 Franklin, TN 37064	(615) 236-4040	
Baptist Ambulatory Surgery Center	(615) 321-7730	STHe Financial Asst. 312 21st Ave. North Nashville, TN 37203		
Saint Thomas Center for Sleep	(615) 222-6638	STHe Financial Asst. PO Box 380 Nashville, TN 37202	(615) 222-7700	

Saint Thomas Health

Financial Assistance Application Form

All Fields are Required to be completed

Type of Financial Assistance Requested: Charity Pre-Qualification

Requested Provider/Facility: ______________________________

Medical Record No.	
Account No.	

PATIENT INFORMATION (PLEASE PRINT)

Patient Name	Birth Date	Marital Status	Sex	Telephone No.
Address	City	State	Zip	Email Address
Social Security Number	Employer		Employment Status	How Many Hours/Week
Employer Address	City	State	Zip	Telephone No.

RESPONSIBLE PARTY'S / GUARANTOR'S INFORMATION (Leave Blank if Same as Above)

Name	Birth Date	Marital Status	Sex	Telephone No.
Address	City	State	Zip	Email Address
Social Security Number	Employer		Employment Status	How Many Hours/Week
Employer Address	City	State	Zip	Telephone No.

RESPONSIBLE PARTY SPOUSE INFORMATION

Spouse's Name		Social Security Number			Birth Date
Spouse's Employer	Address	City	State	Zip	Telephone No.

DEPENDENTS

Name	Age	Relationship	Name	Age	Relationship

Total Household Size

Saint Thomas Health

Financial Assistance Application Form

All Fields are Required to be completed

Income	Amount
Applicant Earned Income	
Applicant Spouse's Income	
Social Security Benefits	
Pension/Retirement Income	
Unemployment Compensation	
Worker's Compensation	
Interest / Dividend Income	
Child Support	
Alimony	
Rental Property Income	
Food Stamps	
Other	
Other	
TOTAL GROSS INCOME:	

TOTAL INCOME - EXPENSES:

Expenses		
Mortgage/Rent		
Electricity		
Gas		
Telephone		
Water		
Groceries		
Cable TV		
Car Payment		
Cell Phone		
Day Care		
Child Support/Alimony		
Prescription Drugs		
Credit Cards:		
1. Credit Card 1 - ____________		
2. Credit Card 2 - ____________		
3 Credit Card 3 - ____________		
Other Doctor / Hospital Bills:		
Doctor/Hospital Bills 1-_________		
Doctor/Hospital Bills 2-_________		
Doctor/Hospital Bills 3-_________		
Doctor/Hospital Bills 4-_________		
Insurance Expense:		
1. Automobile		
2. Property		
3. Medical / Life		
Other Loan Payments:		
1. Loan Payment-_____________		
2. Loan Payment-_____________		
Other Monthly Payments:		
1. Other Payment-____________		
2. Other Payment-____________		
3. Other Payment-____________		
TOTAL MONTHLY EXPENSES:		

COMMENTS: ____

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I hereby certify that the above information is true and complete to the best of my knowledge. I hereby authorize the hospital to obtain information from external credit reporting agencies if the hospital deems necessary.

______________________ ____

Date Signature of Patient, Spouse, Guarantor or Legal Representative

All Fields are Required to be completed

Letter of Support

Medical Record Number / Account Number ______________________________

Supporter's Name ______________________________

Relationship to Patient ______________________________

Supporter's Address ______________________________

To Saint Thomas Health:

This is to advise that *(patient's name)* ____________________________________ receives little or no income and I am assisting with his/her living expenses. He/She has little or no obligation to me.

By signing this statement I agree that the information given is true to the best of my knowledge.

____ ____________________

Signature of Supporter Date