



1150 Varnum St. NE
Washington, DC 20017

PROVIDENCE HOSPITAL FINANCIAL ASSISTANCE PROGRAM

APPLICATION INSTRUCTIONS:

If you wish to apply for the Providence Hospital Financial Assistance Program, please complete and return the attached Application. If you have any questions, Providence Hospital associates are available to answer your questions, and assist you in the completion of this Application.

Your completed Application will be reviewed for a discount based on your household income and the number of dependent persons within your household. If eligible, the discount percentage ranges from 70% to 100%. If you are not eligible for this program, you will automatically receive a 65% discount on your uninsured medical services.

ELIGIBILITY

In order to qualify for Financial Assistance, please note the following:

- An Application for local, state, or federal aid may be required.
- **Household income must be verified. Please provide proof of household income. (Tax return and/or recent pay stubs) If you have no income, please provide a statement explaining how you are supported financially.**
- Other income sources must also be reported and include: child support, alimony, workers compensation, public assistance, self-employment income, and unemployment income.

Financial Assistance is not available for:

- Personal items, such as television expenses.
- Service that is not medically necessary including cosmetic procedures and infertility treatments
- Service covered by insurance in another health care network.
- Over-the-counter pharmaceutical items.

Determination of Financial Assistance shall only be applicable to the episode of care for which this Application is being completed.

Mail application to: Providence Hospital
ATTN: Financial Counseling & Eligibility Services (Ground Flr)
1150 Varnum St., NE
Washington, DC 20017

Fax this application to: (202) 281-3143

Questions regarding this application: (202) 854-4081



FINANCIAL ASSISTANCE APPLICATION

PATIENT INFORMATION (PLEASE PRINT)					Account No.	
Patient Name:	Birth Date	Marital Status	Sex		Telephone No.	
Address:	City	State	Zip	Email Address		
Social Security Number:	Employer	Full Time	Part Time	How many hrs/wk		
Employer Address:	City	State	Zip	Telephone No.		

RESPONSIBLE PARTY'S INFORMATION						
Name	Birth Date	Marital Status	Sex		Telephone No.	
Same as above						
Address		State	Zip	Email Address		
Social Security Number	Employer	Full Time	Part Time	How many hrs/wk		
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

GROSS MONTHLY INCOME			MONTHLY LIVING EXPENSES		Payment	Balance
Applicant Earned Income	_____		Mortgage/Rent	_____		
Applicant Spouse's Income	_____		Electricity	_____		
Social Security Benefits	_____		Gas	_____		
Pension/Retirement Income	_____		Telephone	_____		
Unemployment Compensation	_____		Water	_____		
Worker's Compensation	_____		Groceries	_____		
Interest / Dividend Income	_____		Cable TV	_____		
Child Support	_____		Car Payment	_____		
Alimony	_____		Cell Phone	_____		
Rental Property Income	_____		Day Care	_____		
Food Stamps	_____		Child Support/Alimony	_____		
Other	_____		Prescription Drugs	_____		
Other	_____		Credit Cards:			
TOTAL GROSS INCOME:			1.	_____		
			2.	_____		
			3.	_____		
ASSETS			Other Doctor /			
Cash on Hand	_____		Hospital Bills:			
Savings Account	_____					
Checking Account	_____					
C.D.'s	_____					
Securities	_____					
Life Insurance	_____					
Other Real Estate	_____					
Other	_____		Insurance Expense:			
			1. Automobile	_____		
Vehicle / Make & Model:	Year	Value	2. Property	_____		
			3. Medical / Life	_____		
			Other Loan Payments:			
			1.	_____		
			2.	_____		
Financial Settlements:			Other Monthly Payments:			
Life Insurance	_____		cobra	_____		
Inheritance	_____		life insurance	_____		
Other	_____		3.	_____		
TOTAL VALUE OF ASSETS:			TOTAL MONTHLY EXPENSES:			

COMMENTS: _____

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

PROVIDENCE HOSPITAL
FINANCIAL ASSISTANCE APPLICATION

CERTIFICATION

My signature on this form certifies that all the statements are true to the best of my knowledge and that I have disclosed all facts concerning my finances. I understand and acknowledge that any misrepresentation of my finances in connection with this Application, or any failure to cooperate with efforts to qualify me for programs which may cover the cost of my care (for example, Medicaid, personal injury claim, workmen’s compensation) may invalidate any award of Financial Assistance and that I will be financially liable for the services provided. I agree to allow Providence Hospital or its representatives to request and review a report of my credit and to take other reasonable steps to validate all information provided.

I understand that if I qualify for partial financial assistance I will be responsible for payment of the remaining portion of my bill.

Statement Regarding Gross income (before taxes and withholding)

My Total Yearly Household Income (add the Patient and Spouse Yearly Columns from other side and write the total below):

Statement Regarding Lack of Income

Briefly describe your financial/living situation and why you need financial assistance with your medical bill(s).

Please Sign Below:

Patient /Guardian

(Date)