TRINITY HEALTH OF NEW ENGLAND
FINANCIAL ASSISTANCE APPLICATION

Johnson Memorial Hospital – Mercy Medical Center - Mount Sinai Rehabilitation Hospital
Saint Francis Hospital and Medical Center – St. Mary's Hospital
Trinity Health of New England Medical Group - Collaborative Laboratory Services
Mercy Inpatient Medical Associates

DEMOGRAPHIC INFORMATION			
Patient's Last Name:	Patient's First Name:	Date of Birth:	
Address:			
Home Phone:	Cell Phone:	Marital Status:	Spouse's Name:
Patient's Employer:	Patient's Employer Address:		Employer's phone:
Spouse's Employer:	Spouse's Employer Address:		Spouse's Employer's phone number:

INCOME INFORMATION		
Gross Monthly Income:	Patient $	Spouse $
Other Family Income:		
State/Public Financial Assistance:		
Alimony Income:		
Social Security/Disability/ VA Benefits:		
Retirement/Pension Income:		
Interest/ Dividends/Annuities:		
Other Income:		
Explain Other Income:		

SELF EMPLOYMENT, BUSINESS, RENTAL INCOME:		
Business /Rental Income:		
Business/Rental Expenses:		
Net Business/Rental Income:		
Total Combined Household Income:		

TOTAL NUMBER OF HOUSEHOLD MEMBERS: #

Was your medical condition a result of an accident or injury? (Y/N) **Have you retained an Attorney (Y/N)**

If yes, list name and phone number

I certify that the above information is true to the best of my knowledge and by signing this form; I agree to allow THONE to check employment for the purpose of determining my eligibility for financial assistance or a financial discount. I understand that I may be required to provide proof of the information listed on the application. I understand that this application is made so that the hospital can judge my eligibility for Financial Assistance, based on the established criteria of the hospital. If any information I have given proves to be untrue, I understand the hospital may re-evaluate my financial status and take whatever action is appropriate. I also understand all information requested must be received within (30) days from date of this request. I understand that I may incur additional charges from other professional entities of which I may be responsible for including but not limited to Anesthesiology, Radiologists, and Pathologists.

Person Completing Application:

Applicant's Signature **Date of Request:**

ELIGIBILITY DETERMINATION

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(FOR OFFICE USE ONLY):	
Guarantor Name:	Medical Record Number:
Received By:	Received Date:
☐ Income ☐ Tax Return ☐ Identification ☐ Residency ☐ Medicaid Determination letter	

☐ **Eligible (For the next 6 months)**

☐ **Eligible (Non-service area residents Emergency/Urgent Care Only)**

☐ **Eligible Catastrophic Event Coverage**

The applicant is eligible for: ☐ Partial (Medicare Rate) or ☐ Full Assistance (100%)

Financial Assistance Fund $ ___________________

New Balance $_______________________________

☐ **Denied**

☐ **Denied (Non-resident does not meet criteria for on-going coverage)**

The applicant's request for Financial Assistance Funds has been denied for the following reasons (s):

______Over –Income

______Did not purse available resources or failed to comply

______No income

______Other reason: ____

Authorized Signature: _____________________________________ Determination Date: __________________