[CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE]

[For Hospital and Professional services provided by facilities and physicians of Trinity Health]

[Please complete and sign application form and return within 10 days including copies of the following:]
[Required Verifications] ☐ [Past One month Proof of Gross Income] ☐ [Past Two months Complete Bank Statements for all bank accounts, with all pages included (explanation for recurring deposits)] ☐ [Recent Tax Returns (1040 form with Schedule C, E or F) or Three Months Profit and Loss Statements (for self-employed/dependents)] [Provide the following, If applicable] ☐ [Recent W2 for Seasonal Income] ☐ [Unemployment Benefit/ Denial letter] ☐ [Child Support Income/Alimony] ☐ [No Income – Complete Letter of Financial Support portion of the application]

Patient Information			
[Patient Name]		[Date of Birth]	
[Social Security/EIN Number (optional)]	[Mobile Phone]	[Other Phone]	
[Mailing Address]	[City]	[State]	[ZIP code]
[Email Address]	[Of what state are you a resident?]		
[Marital status (optional)] □[Single] □[Married] □[Divorced] □[Other] _____			
[Do you file a Federal Tax Return?] □ [Yes] □ [No] [If no, why?]	[Can you be claimed as dependent on someone else's tax return?] □ [Yes] □ [No]		
[Did you or your dependents have health insurance coverage at the time of service?] □[Yes] □[No] [(Provide Insurance card copy)]			
[Are you a documented resident of the United States? (optional)] □ [Yes] □ [No] □ [Prefer Not to Answer]			

[Household Members, including yourself based on your recent Tax Returns]	[Date of Birth]	[Relationship to Patient]	[Claimed on Tax Return (Yes/No)]

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[Income Verification for all household members]

[Monthly Income Source]	[Who receives this?]	[Gross Monthly Income (before taxes)]	[Monthly Income Source]	[Who receives this?]	[Gross Monthly Income (before taxes)]
[Social Security/Disability]			[Worker's Compensation]		
[Pension]			[Unemployment]		
[Self-Employment]			[Child Support/Alimony]		
[Public Assistance]			[Rental Land Income]		
[Other]					

[Letter of Financial Support - Should only be completed by the person providing support]

☐ [I provide more than 50% support for the patient's living expenses, but I am unable to help with medical bills.]

☐ [By signing this letter, I verify that the above statement is correct and that I will in no way be held liable for the patient's bills. If you have questions, please contact me at _____ (Phone Number)]

[Name of person providing support]	**[Relationship to Patient]**
[Signature of person providing support]	**[Date]**

[VERIFICATION OF INCOME AND IDENTIFICATION]

[I certify that the information listed in this application is true and complete to the best of my knowledge. I understand that the information provided is subject to verification. I will be responsible for repayment of any services provided at Trinity Health affiliates if the above information is provided under false pretenses.]

[Signature of Patient]: _____
[Date]: _____

[Or Signature of Legal Guardian (If Applicable)]: _____
[Date]: _____

[Relationship to Patient]: _____
[Date]: _____

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[Please mail your application to the address above, fax at 312-871-3350 and or upload documents through MyChart (Patient Portal) - https://mychart.trinity-health.org/MyChart If you have any questions, please contact our Customer Service Center at 833-961-2453 Monday through Friday 9 a.m. -5 p.m. ET.]