St. Elizabeth Physicians
2300 Chamber Center, Suite 300
Ft. Mitchell, KY 41017
859-344-5555

Dear Valued Patient,

Thank you for your interest in the St. Elizabeth Physicians Financial Hardship program.

Please complete the application attached to this letter listing all members of the household and their income. The following documentation must be included in order to process your application: Copies (**do not send originals**) of proof of income which includes your prior year tax return and your three most recent pay stubs. If you have an income source other than employment, such as social security, unemployment, food stamps, child support, etc., please send a copy of the award letter stating your monthly or weekly benefit amount. If you have no income, please attach a detailed, ***notarized*** letter explaining how you are obtaining food, housing, transportation, etc.

If verification of income is not included your application will be returned with a request for the documentation.

You may submit your application by any of the following ways:

- Via Mail: St. Elizabeth Physicians
  Attn: FHA
  2300 Chamber Center Dr. Ste 300
  Ft. Mitchell, KY 41017
- Via Email: SEPCollections@stelizabeth.com
- Via Fax: 859.795.5461
- In Person: You may drop off at any of our St. Elizabeth Physician locations

Applications will be processed upon receipt of all requested documentation. All applicants will receive notification by mail stating approval or denial in the program.

This application does not apply to bills you may be receiving from St. Elizabeth Healthcare.

PLEASE ALLOW AT LEAST 30 DAYS FOR PROCESSING.

If you have any questions, please call 859-344-5555 Monday through Thursday between the hours of 8:00 a.m. and 5:30 p.m. and Friday between the hours of 8:00 a.m. and 4:00 p.m.

Thank you,

St. Elizabeth Physicians

Account:_____

ST. ELIZABETH PHYSICIANS

Patient Application for Discounted Medical Services
For Office Based Physicians
(*This application does not apply to bills from St. Elizabeth Healthcare.*)

Name:_____ SSN:_____

Address:_____ Phone:_____

_____ Employer:_____

Household Member Name's	Account Number	DOB	SSN	Monthly Income
Patient				
Spouse				
Dependent				
Dependent				
Dependent				
Dependent				

To qualify for financial assistance, you must be at or below the federal poverty guidelines listed below:

Number in Family	Federal Poverty Threshold	150%	200%
1	$12,140	$18,210	$24,280
2	$16,460	$24,690	$32,920
3	$20,780	$31,170	$41,560
4	$25,100	$37,650	$50,200
5	$29,420	$44,130	$58,840
6	$33,740	$50,610	$67,480
7	$38,060	$57,090	$76,120
8	$42,380	$63,570	$84,760
Each additional person add	$4,320	$6,480	$8,640
Income below above amount			
Discount fees by	75%	65%	50%

Updated 01.13.18

I attest that the above information is current and accurate.

Patient Signature:_____ **Date:**_____

For office use only—DO NOT COMPLETE BELOW THIS LINE

Approved:_____ Discount percentage for which patient is entitled: **50%** **65%** **75%**

Denied:_____ Reason denied:_____

St. Elizabeth Physicians' Authorizing Signature: _____Date: _____

Received:_____

St. Elizabeth Physicians
St. Elizabeth Physicians Services
2300 Chamber Center Dr. Ste. 300
Ft. Mitchell, KY 41017
Phone: 859-344-5555
Fax: 859-795-5461
Email: SEPCollections@stelizabeth.com

Patient:_____ Date:_____
SEP Account #:_____ SEPS Account #:_____

Thank you for your interest in our financial hardship program. Please answer the following questions below and return using the enclosed envelope. Please provide copies of the requested documentation ***for all members of the household***. If specific documentation is not included we will be unable to process your application.

Please answer the following questions, if answering yes please provide the required documents with your application.

Yes/No	Question	If Yes, Required Documents
	Do you file taxes	Most recent federal tax return
	Is anyone in the home employed	3 most recent consecutive pay stubs per person
	Do you receive Social Security	Monthly Benefit Letter
	Do you receive Disability	Monthly Benefit Letter
	Do you receive food stamps	Determination Letter
	Do you receive Child support	Documentation of ordered amount
	Do you receive unemployment	Benefit Letter
	Do you receive retirement/pension income	Monthly Benefit Letter or Bank statement
	Are you Self-Employed	2 Month income/expense report
	Do you have any income not mentioned	Documentation to support
	Are you claiming $0 income	Notarized letter explaining how you obtain food and housing
	Are you a Nursing Home resident	Monthly statement

Please provide the following information based on average income over the last 12 months.

Monthly Family Income & Source			
	Patient	Spouse	Dependents
Monthly Salary (Gross)	$	$	$
Unemployment Benefits	$	$	$
Social Security	$	$	$
Workman's Compensation	$	$	$
Child Support	$	$	$
Alimony	$	$	$
Short/Long Term Disability	$	$	$
Retirement/Pension	$	$	$
Self-Employment	$	$	$
Other	$	$	$
Total Family Income	$		

Other information you would like to provide:_____

_____

_____

Please note documentation is required for all household members. Failure to provide necessary documentation may result in a delay in getting the application processed or a denial.