Dear Valued Patient,

Thank you for your interest in the financial hardship program for St. Elizabeth Physicians, St. Elizabeth Physician Services and St. Elizabeth Family Practice Center.

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's tax return and your most recent pay stub. If you have income other than employment, such as social security, unemployment, retirement, etc., please send a copy of the award letter stating your monthly or weekly benefit amount. If you have no income, please complete the attached verification 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. If not completed your application may be denied.

You may submit your application any of the following ways:

- Via Mail: St Elizabeth Physicians
  1360 Dolwick Dr. Ste 200
  Erlanger, KY 41018
- Via MyChart: Access your MyChart account to apply
- Via E-mail: 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. Provided all documents are received, notification will be sent by mail stating approval or denial in the program. We highly encourage all applicants to arrange a payment plan on all accounts while in the application process.

This application may also 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.

Patient Application for Financial Assistance for St. Elizabeth Hospital and Physician Visits

This single financial assistance application form may be used for both hospital and physician services. However, hospital and physician services utilize different income parameters to qualify patients, award different discount percentages, and will communicate approval or denial independently.

Full Name:_____ Phone:_____

Address:_____ Employer:_____

_____

Family Member Name's	Account Number (list just one if applicable)	DOB	SSN
Patient:			
Spouse:			
Dependent:			
Dependent:			
Dependent:			
Dependent:			
Dependent:			
Dependent:			

Financial assistance qualification is determined upon the applicant's household income, as a percentage above the federal poverty guidelines.

Please answer the following questions below, if answering yes please provide the required documents with your application. Please provide copies of the requested documentation ***for all adult family members***. "Family" shall include any dependent claimed for federal tax purposes. If specific documentation is not included, we will be unable to process your application**.**

Yes/No	Question	If Yes, Required Documents
	Do you file taxes	Most recent federal tax return
	Is anyone in the home employed	Most recent pay stub per person
	Do you receive Social Security	Annual Award Letter
	Do you receive Disability	Annual Award Letter
	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	Zero Income Verification (attached)

Do you have any real estate or financial assets such as savings acct? **Yes / No**

If Yes, please explain: _____

_____

_____

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

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

Monthly Expenses

Housing……. $_____ Utilities…….. $_____ Household Expenses…….. $_____

Automobile……... $_____ Other……. $_____ (food, etc.)

Other information you would like to provide: _____

_____

_____

Upload completed application and income documents through your St. Elizabeth MyChart account.

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

I attest that the above information is current and accurate:

Patient Signature:_____ **Date:**_____

Spouse Signature:_____ **Date:**_____

For additional information on St. Elizabeth hospital or physician financial assistance programs, please visit:
https://www.stelizabeth.com/resources/pay-my-bill
https://www.stelizabethphysicians.com/resources/pay-my-bill/

Zero Income Verification

I, _____, confirm:

1. My place of residence is:

   _____.

2. I am (please circle one): **single married separated divorced.**
3. I claim the following dependents (names & DOB):

   _____

   _____

4. I have been unemployed since (month/year): _____.
5. I currently have no income of any kind including salary and wages, interest income, dividend income, social security, workers compensation, disability payments, unemployment income, business income, rentals and royalties, inheritance, strike benefits, alimony income, and/or payments received from the state for legal guardianship or custody.
6. I am currently obtaining food and housing through the following sources:

   _____

   _____

Patient Signature:_____

Date:_____