St. Elizabeth Physicians
St. Elizabeth Physician Services
St. Elizabeth Family Practice Center
(859) 344-5555

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 tax return and your three most recent pay stubs. If you have an income source 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
  Attn: FHA
  1360 Dolwick Dr. Ste 200
  Erlanger, KY 41018
- Via Email: SEPCollections@stelizabeth.com
- Via Fax: 859.795.5461
- In Person: You may drop off at any of your 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. We highly encourage all applicants arrange a payment plan on all accounts while in the application process.

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 4:30 p.m.

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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 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.

Please answer the following questions, of 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 unemployment?	Benefit letter
	Do you receive retirement/pension income?	Monthly Benefit Letter or bank statement
	Are you self-employed?	2 monthly income/expense report
	Do you have any income not mentioned?	Documentation to support
	Are you claiming $0 income?	Zero Income Verification (attached)

Please provide your monthly family income and source based on average income over the last 12 months.

Income	Type (Ex:Pay Stubs, SSI, etc.)	Frequency	Hours/Week	Amount
Patient				$
				$
Spouse				$
				$

Other information you would like to provide:_____
_____

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

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Household Members Name	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:

Account	Number in Family	FPL	150%	200%
St. Elizabeth Physicians	1	$12,760	$19,140	$25,520
	2	$17,240	$25,860	$34,480
	3	$21,720	$32,580	$43,440
	4	$26,200	$39,300	$52,400
	5	$30,680	$46,020	$61,360
	6	$35,160	$52,740	$70,320
	7	$39,640	$59,460	$79,280
	8	$44,120	$66,180	$88,240
	Each additional person add	$4,480	$6,720	$8,960
	Income below about amount			
	Discount fees by	75%	65%	50%

Account	Number in Family	FPL 200%	300%	400%
St. Elizabeth Physician Services Family Practice Center	1	$25,520	$38,280	$51,040
	2	$34,480	$51,720	$68,960
	3	$43,440	$65,160	$86,880
	4	$52,400	$78,600	$104,800
	5	$61,360	$92,040	$122,720
	6	$70,320	$105,480	$140,640
	7	$79,280	$118,920	$158,560
	8	$88,240	$132,360	$176,480
	Each additional person add	$8,960	$13,440	$17,920
	Income below about amount			
	Discount fees by	100%	50%	25%

I attest the above information is current and accurate.

Patient Signature_____ Date_____

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Zero Income Verification

I _____ confirm,

1. My place of address 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_____
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 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_____