BON SECOURS HEALTH SYSTEM
FINANCIAL ASSISTANCE APPLICATION Date Sent _____

Facility _____Account #_____
Patient Last Name_____ First_____ MI_____
SS#_____ Date of Birth_____ Marital Status_____Phone#_____
Patient Address_____
Employer_____ Spouse's Employer_____

Family Members (List spouse and dependent children under 18 years, or as listed on your taxes and their date(s) of birth):

Name	***Date of Birth***	**Name**	**Date of Birth**
1. _____	/ _____	4. _____	/ _____
2. _____	/ _____	5. _____	/ _____
3. _____	/ _____	6. _____	/ _____

APPLICANTS MUST SUBMIT ALL REQUIRED DOCUMENTS IN THE SAME MAILING TO:
Bon Secours Financial Assistance Program
P.O. Box 742431
Atlanta, GA 30374-2431

Please answer <u>each</u> question and provide the information requested
UNINSURED PATIENTS MUST PARTICIPATE WITH OUR INSURANCE ELIGIBILITY VENDOR PRIOR TO RECEIVING ASSISTANCE
DECISIONS WILL BE RENDERED WITHIN 60 DAYS OF RECIEPT OF COMPLETED APPLICATION AND PARTICIPATION WITH OUR VENDOR

Please answer all questions listed below	**If YES, please provide the following for <u>EACH</u> member of the household receiving the benefit.**
Is any member of your household **self-employed?** ❑ YES ❑ NO	COMPLETE TAX form(s) including business taxes from the most recent tax year and latest quarterly filing listing income for quarter
Is any member of your household **employed**? ❑ YES ❑ NO	3 most recent pay stubs or signed letter from employer
Is any member of your household receiving **unemployment benefits?** ❑ YES ❑ NO	Benefit letter or Unemployment printout from State website
Is any member of your household receiving **Social Security**? ❑ YES ❑ NO	SS benefit letter or complete bank statement if direct deposited
Does any member of your household receive a **Pension or Retirement**? ❑ YES ❑ NO	Pension/Retirement letter or complete bank statement if direct deposited
Does any member of your household receive **SNAP benefits**? ❑ YES ❑ NO	SNAP Letter
Does any member of your household receive a **Child Support**? ❑ YES ❑ NO	Court ordered document or letter from non-custodial parent
Does any member of your household own **rental or investment property**? ❑ YES ❑ NO	Rental agreement/documentation listing income amount
Does any member of your household have **other sources of Income**? ❑ YES ❑ NO	Stocks, Bonds, CD's additional property, etc… Attach current statement(s)
Does any member of your household have a **checking, savings or money market account** ? ❑ YES ❑ NO	Attach complete copy of current 30 day statement for <u>each</u> account

NO INCOME: ❑ YES ❑ NO

If your household is claiming no income you must have the person providing your food, shelter, and daily living expenses sign below and indicate which type of assistance they are providing

*I certify that I (**name**)_____(**phone number**)_____*
provide food, shelter, and daily living expenses for the patient listed above and/or income of $_____Monthly
Assistance provided:_____
***Signature**_____**Relationship**_____**Date**_____*

If patient is on a student or tourist on a visa, provide a copy of visa and all insurance, financial and/or sponsorship information provided to obtain the visa.

>>>Continued<<<

BON SECOURS HEALTH SYSTEM

BON SECOURS HEALTH SYSTEM
FINANCIAL ASSISTANCE APPLICATION

Patient Last Name_____ First_____ MI_____

Personal Asset Value List

Annual Household Income	_____	CD's (Cash Value)	_____
Cash on Hand/Money in Bank/Savings Acct(s)	_____	Primary residence (Cash Value)	_____
Monthly Rent	_____	Other Real Estate (Cash Value)	_____
Monthly Mortgage payment	_____	401k (Cash Value)	_____

Was treatment for this service due to an accident? Yes_____ No____ (**Financial Assistance program does not apply to treatment related to work injuries, cosmetic procedures or flat rate procedures, accidents or other treatment for which you receive compensation for your medical bills, pain and suffering and other damages).**

Do you have health insurance ❑ YES ❑ NO (If YES, please provide further information below)

1. Insurance Name_____ Policy Holder Name _____ Policy#_____
2. Insurance Name_____ Policy Holder Name _____ Policy#_____

I hereby request that Bon Secours Health System Inc., make a written determination of my eligibility for financial assistance. I understand that, if the information which I submit is determined to be false, such determination may result in a denial of my application and that I may be liable for charges for services provided. I certify that the above information is true, complete, and correct to the best of my knowledge. I acknowledge that cooperating with the eligibility screening vendor is required to be considered for financial assistance.

Additional Comments

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature of Responsible Party: _____ Date: _____

Bon Secours Health System Inc., reserves the right to validate information reported in the Financial Assistance application, such efforts to validate personal income or lack thereof, will be conducted in such a manner as to maintain the utmost confidentiality and in no way generate any report by any credit bureau agency that could adversely affect the privacy of the applicant.

If you need additional assistance, please visit a financial counselor at your local Bon Secours hospital or call our Customer Service Department.

Local Richmond 804-342-1500
Toll Free 877-342-1500
Monday – Friday 8:30 AM to 1:00 PM and 2:00 PM to 7:00PM