Dignity Health.
St. Rose Dominican

HELPING HANDS FINANCIAL ASSISTANCE APPLICATION

The Helping Hands Program provides financial assistance for our patients who:

✓ **Are uninsured** ✓ **Are underinsured**

Each patient's situation will be evaluated according to relevant circumstances, household income, other financial resources available to the patient or patient's family, and outstanding medical balances.

DO I QUALIFY?

- ✓ Patients with a household income at or below 200% of the Federal Poverty Guidelines (FPG) may receive a 100% discount.
- ✓ Patients with yearly Family Income from greater than 200% up to 500% of FPG, with medical bills exceeding 10% of their yearly Family Income may also be eligible for a discount.

WHAT INFORMATION IS NEEDED?

- ✓ Provide the account number that the financial assistance may be applied to: _____
- ✓ Fill out the attached Financial Assistance Application
- ✓ Most recent tax return (include all pages not just summary pages)
- ✓ 4 consecutive paycheck stubs (most recent)
- ✓ 3 months of consecutive bank statements (include all pages not just summary pages)
- ✓ Copies of all outstanding household medical bills
- ✓ Copies of qualification letters for other financial or government assistance

Send the completed application and **all** requested documents by Registered Mail to the following address:

Dignity Health – St. Rose Dominican Neighborhood Hospital– Central Billing Office
Attn: Customer Service Department
8686 New Trails Drive, Suite #100
The Woodlands, TX 77381

APPLICATION QUESTIONS?

- ✓ If you need assistance in completing the application, please contact a Customer Service Representative at 877.516.0911, Option 1 (Monday – Friday 8:00 am – 5:00 pm CST).

HOW WILL I BE NOTIFIED?

Should the patient application qualify for Helping Hands Financial Assistance Program benefits, they will be contacted via telephone by a Customer Service Representative.

A Spanish language version of this communication is available upon request.

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Financial Assistance Application

Applicant Information

Patient Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: ( ) _____ Social Security Number: _____

Date of Birth: _____ ☐ Male ☐ **Female**

Person submitting application: _____

Relationship: _____

Marital Status: ☐ **Married** ☐ **Single** ☐ **Widowed**

Spouse Information (If Applicable)

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: ( ) _____ Social Security Number: _____

Date of Birth: ☐ Male ☐ **Female**

Household Information

I and or my spouse receive public assistance: ☐ **Yes** ☐ **No** **Type:** _____

Please list all dependents in household under 21 years of age

Name	Date of Birth	Relationship

Income Information

Are you currently employed? ☐ **Yes** ☐ **No** **If yes, what is your monthly income?** _____

Is your spouse currently employed? ☐ **Yes** ☐ **No** **If yes, what is your monthly income?** _____

Please check any other income that you receive.

☐ Social Security
☐ Veterans Benefits
☐ Pension
☐ Unemployment
☐ Support Payments
☐ Disability
☐ Rental Property
☐ Other

Additional Monthly income total: _____

Additional Information

Health Insurance Carrier: _____ **ID #** _____

Insured Name _____ **Group #** _____

Emergency Room Benefits:

Deductible: _____

Coinsurance: _____

Visit Information

Date of Service: _____

Reason for your visit: _____

Diagnosis: _____

Amount covered by insurance: _____ Amount paid by patient: _____

Please provide the following information:

1. Please list monthly expenses (rent, mortgage, utilities, etc.)

Expense	Amount	Expense	Amount	Expense	Amount

2. Please list and explain any relevant medical expenses that you currently have and attach copies of bill

Expense	Amount	Expense	Amount	Expense	Amount

3. Please use the following space to explain your situation further if necessary.

I understand Dignity Health – St. Rose Dominican Neighborhood Hospital may verify the financial information contained in this application in connection with the evaluation of this application, may contact my employer to certify the information provided, and may request reports from credit reporting agencies. I am aware this information is used to determine my eligibility for financial assistance. I agree Dignity Health – St. Rose Dominican Neighborhood Hospital may contact these sources to update the information at any time. I am aware that falsification of information on this application may result in denial of financial assistance.

_____

Printed Name

_____ _____

Signature Date