Seton | Ascension

Dear Patient,

Thank you for choosing Ascension Seton. Ascension Seton is a Catholic healthcare ministry whose mission inspires us to care for and improve the health of those we serve with the special concern for the poor and the vulnerable. In support of our mission, we provide financial assistance to patients who cannot afford medical care.

At your request, we have provided you a financial assistance application. Please complete the application, including your **signature** and **date** before returning it to Patient Financial Services to be processed.

In addition to the application page, you are required to submit proof of income documentation for all income in your family for this application to be considered. Incomplete applications will not be processed. **Additionally, we require that all other available funding sources be utilized prior to assessing charity eligibility.**
For the purposes of determining eligibility, income includes total annual/monthly cash receipts before taxes from all sources, including but not limited to:

- Monetary wages and salaries before any deductions
- Net receipts from farm self-employment (receipts from a farm which one operates as an owner, renter, or sharecropper, after deductions for farm operating expenses)
- Net receipts from non-farm self-employment (receipts from a person's own unincorporated business, professional enterprise, or partnership, after deductions for business expenses)
- Social Security
- Railroad retirement
- Unemployment compensation
- Strike benefits from union funds
- Workers' compensation
- Veterans Benefits
- Public Assistance (including Aid to Families with Dependent Children or Temporary Assistance for Needy Families [TANF], Supplemental Security Income [SSI], etc.)
- Training stipends
- Alimony or child support
- Military family allotments or other regular support from an absent family member or someone not living in the household
- Pensions (private, government, military retirement, annuities)
- College or University scholarships, grants, fellowships, and assistantships
- Dividends and interest
- Rental Income
- Periodic receipts from estates or trusts
- Net gambling and lottery winnings

Proof of income documentation includes the following:

- Most recent year tax return **[*PREFERRED*]**
- Two most recent pay stubs for each working family member
- Letter from employer on *company letterhead* verifying compensation
- Notification of Unemployment Benefits
- Proof of Social Security Income
- Proof of regular withdrawals from trusts or retirement income
- Letter of support from family member ***[Notary Preferred]***
- Documentation of other forms of income; *Child Support, Alimony, etc*
- Letter of determination for government assistance programs; *Food Stamps, WIC, Subsidized Housing, etc.*

(Continue on back)

- Letter of determination for any publicly funded programs or third party payment sources
- Official school transcript
- Proof of address; *utility bill, bank statement, credit card statement, etc. no older than 3 months*

Please note: Financial assistance is not intended to replace reasonable financial planning, health insurance coverage, or available public funding for which you may qualify.

If you have questions or need assistance completing this form, please direct your calls as indicated below:

Ascension Seton	**Ascension Seton Smithville**	**Ascension Medical Group**
LOCAL: (512) 324-1125 *Select Option #4 then Option #3* **Long Distance Toll Free: 1-800-749-7624** *Select Option #4 then Option #3*	(512) 237-5742	(512) 324-8960

Ascension Seton Shoal Creek
(512) 324-2025

Please **mail** your completed application and proof of income documents to the appropriate address listed below:

Patient Financial Services **Ascension Seton** Attn: Financial Counselors P.O. Box 204398 Dallas, TX 75320-4398	**Ascension Seton Smithville** **Attn: Business Office** Representative P.O. Box 204233 Dallas, TX 75320	**Medical Group Financial Assistance Department** 10330 North Meridian St, 2nd Floor Indianapolis, IN 46290 Email: FinancialCounselors@ascension.org Fax: (317) 981-6312

Ascension Seton Shoal Creek **Attn: Patient Financial Services** 3501 Mills Avenue Austin, TX 78731

Sincerely,

Patient Financial Services
Ascension Seton

Seton | Ascension

Financial Assistance Application

Seton Acct. #(s): _____ **Acct. Balance(s):** _____ **MRN(s):** _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Patient Name: _____

Social Security # _____ **Date of Birth:** _____ **Marital Status:** _____

Guarantor: _____ **Guarantor's Social Security #:** _____

Street Address: _____ **Phone #:** _____

City: _____ **County:** _____ **State:** _____ **Zip Code:** _____

Income Information

# of Dependents: _____ **Number of Individuals Receiving Income:** _____ **Monthly Gross Wages: $**_____

Monthly Unemployment: $_____ **Monthly Child Support: $**_____ **Monthly Alimony: $**_____

Trust Fund Receipts: $_____ **Monthly SSI Benefits: $**_____ **Other Monthly Income: $**_____

TOTAL MONTHLY INCOME $_____

SUPPORTING DOCUMENTATION MUST BE PROVIDED FOR EACH TYPE OF INCOME LISTED

Government Assistance

Please *CHECK* all that apply

☐ **Food Stamps** ☐**WIC (Women, Infants, and Children)** ☐**Subsidized Housing**

☐**MAP** ☐**CCHC** ☐**Texas Medicaid/CHIP** ☐**Medicaid (a state *other than* Texas):** _____

☐ **County Indigent Care Program (county name):**_____

☐ **Seton Care Plus (SCP)** ☐ **Music Seton Care Plus (MSCP)**

SUPPORTING DOCUMENTATION MUST BE PROVIDED FOR EACH TYPE OF ASSISTANCE CHECKED

Asset Information Section

Include *all* applicable values

☐ **Stocks**	**Value$**_____	☐**Bonds**	**Value$**_____
☐**IRAs**	**Value$**_____	☐**Secondary Residence**	**Value$**_____
☐**Boat**	**Value$**_____	☐**Collector Automobiles**	**Value$**_____
☐**RV**	**Value$**_____	☐**Non-Essential Automobiles**	**Value$**_____
		☐**Other Luxury Items**	**Value$**_____

TOTAL VALUE OF ASSETS $_____

CERTIFICATION: I certify to the best of my knowledge and believe the above information is true, correct, and complete. I understand that the information may be disclosed for uncompensated care reporting purposes.

Patient/Guarantor Signature: _____ Date: _____

Completed by: _____ Date: _____