ARIZONA SPINE & JOINT HOSPITAL Financial Assistance Application Form Instructions

This is an application for financial assistance at CommonSpirit Health.

CommonSpirit Health provides financial assistance to people and families who meet certain income requirements. You may qualify for free care or discounted care based on your family size and income, even if you have health insurance. Assistance is provided for those patients whose family income is lower than 400% of the Federal Poverty Level Guidelines. Information on the Federal Poverty Level Guidelines can be found at http://aspe.hhs.gov/poverty-guidelines.

<u>What does financial assistance cover?</u> The hospital financial assistance covers appropriate hospital-based services provided by CommonSpirit Health depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

<u>If you have questions or need help completing this application:</u> You may obtain help for any reason, including disability and language assistance at: 4620 E. Baseline Road Mesa, AZ 85206. Attention Business Office Manager. Office phone# (480) 308-7710

In (order f	or your app	plication to be p	processed,	you must:
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Provide us information about your family
Provide us information about your family's gross monthly income (income
before taxes and deductions)
Provide documentation for family income
Provide documentation for family assets
Attach additional information if needed
Sign and date the form
-

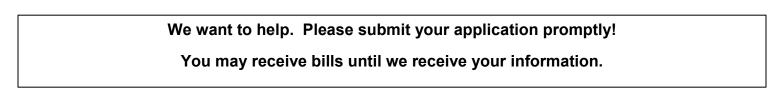
Note: You do not have to provide a Social Security number to apply for financial assistance. If you provide us with your Social Security number, it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

Mail or fax completed application with all documentation to: 4620 E. Baseline Road Mesa, AZ 85206. Fax# (480) 824-1269. Be sure to keep a copy for yourself.

To submit your completed application in person: Business Office Department.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 30 calendar days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.



ARIZONA SPINE & JOINT HOSPITAL

Financial Assistance Application Form – Confidential

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

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		SCREENING II				
Do you need an interpreter?						
Has the patient applied for Me assistance					_	
Does the patient receive state □ No	public se	rvices such as food	stam	nps or WIC (Wo	men, Infants, and Chil	dren)? □ Yes
Is the patient currently homele	ess? 🗆 Ye	s 🗆 No				
Is the patient's medical care r	need relate	ed to a car accident	or wo	ork injury? 🗆 Ye	s □ No	
List of CommonSpirit Health h	. (/	PLEASE	NO1	ΓE		
 We cannot guarantee that you will qualify for financial assistance, even if you apply. Once you send in your application, we may check all the information and may ask for additional information or proof of income. 						
	PA	TIENT AND APPLIC	CAN	T INFORMATIO	N	
Patient first name				Patient last name		
Date of Birth		Patient Account Numbers:		Patient Social Security Number (optional*)		
Person Responsible for Payir	Relationship to Pati	ient	Birth Date	Social Security Number (optional*)		
Mailing Address	· ·					
	Main contact number(s)					:r(s)
() Email Address:						
City State Zip Code						
Employment status of person		le for paying bill			-L	
□ Employed (date of hire:□ Self-Employed □	Student) □ Un □ Disabled		oloyed (how lon □ Retired) ,
□ Sen-Employed □	Student		<u>. </u>	Retired	Other ()
		FAMILY INFO	ORM	ATION		
List family members in your household, including you. "Family" includes two or more people related by birth, marriage, or adoption who live together. If a patient can claim someone as a dependent on his or her income tax return, that person would be a member of the Patient's family for purposes of this Application.						
FAMILY SIZE Attach additional page if needed						
Name	Date of Birth	Relationship to Patient	oldei Emp	years old or r: loyer(s) name or ce of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?

					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No
All adult family members' in - Wages - Unemployment - Child/spousal support - Wo - Other (please identify:	- Self-en	nployment - Worl	cer's compensation	- Disability - SSI	utions

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INCOME INFORMATION

REMEMBER: You must include proof of income with your application.

You must provide information on your family's income. Income verification is required to determine financial assistance.

All family members 18 years old or older must disclose their income. Please provide proof for every identified source of income.

Examples of proof of income include:

- Last year's income tax return, including schedules if applicable; or
- A "W-2" withholding statement; or
- Current pay stubs (3 months); or
- Written, signed statements from employers or others; AND
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with a signed statement explaining how you support basic living expenses (such as housing, food, and utilities).

ASSET INFORMATION

REMEMBER: You must include proof of assets with your application.

You must provide information on all assets owned by any family member. Asset verification is required to determine financial assistance.

All family members 18 years old or older must disclose their available financial resources. Please provide proof for every identified asset source Examples of proof of income include:

- Current bank statements (showing most recent 3 months)
 - Checking Account(s)
 - Savings Account(s)
- Investments, including stocks and bonds
- Trust funds
- Money Market Account(s)
- Mutual funds
- Other investment funds that will not incur a penalty if funds are withdrawn.

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that CommonSpirit Health may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

- I certify that the information I have provided is true and accurate to the best of my knowledge.
- I will independently or with the assistance of hospital personnel apply for ANY and ALL Assistance which may be available through federal, state, local government and private sources to help pay this healthcare bill.

- I understand that if I do not cooperate with CommonSpirit Health in providing requested information, my application may be denied.
- I understand that the information which I submit is subject to verification by CommonSpirit Health, including credit reporting agencies and subject to review by Federal and/or State agencies and others as required.
- I understand that additional information may be requested in order to qualify for assistance.

Tunderstand that additional information may	be requested in order to quality for assistance.
	workers compensation plan, or any other third party, you agree pital retains its right to collect the original, full billed charges e hospital's services.
Signature of Person Applying	 Date