Thank you for choosing SCL Health for your healthcare needs. Sisters of Charity of Leavenworth Health System is proud to provide quality and affordable healthcare for the community. We are here to assist those who are in need of financial assistance and to help those who may have questions or need guidance making health care choices for themselves and their families.

SCL Health has a program to help patients who need financial assistance with paying all or part of their bills. To apply for this program, please fill out the information on the attached financial assistance application.

In order to process your application, we also require supporting documentation. A list of required documents can be found on page four (4). This information must be received within 15 days from the date of this letter if received in person. If you feel that you need to explain your situation further in order to obtain financial assistance, additional space has been provided at the end of the application.

It is important that applications be filled out completely and returned with required documents. Failure to do so will slow down processing the application and possibly be reason for denial. Applications received without a signature will be denied.

If for any reason the above information cannot be obtained, please call the Revenue Service Center at 303-813-5400 or 1-866-665-2636 between the hours of 8 a.m. and 4:30 p.m. We will be more than happy to assist you.

Once a decision has been made regarding your account, you will be notified by a mail with the results of our decision.

Sincerely,

Financial Coordinator
SCL Health
Health Care Financial Assistance Application

General Information

Patient Name_______________________________________ Account # ______________________
Social Security Number _______________________________ Date of Birth ______________________
Address _____________________________________________________________________________
City________________ State_______ Zip________ County_______________________________
Home Phone # ________________ Cell Phone # ______________ Work Phone #________________
Email _________________________________________
  □ Single □ Married/Significant Other □ Divorced/Separated □ Widow/Widower

Responsible Party Name _____________________________ Relationship ______________________
Social Security Number ______________________________ Date of Birth ______________________
Address _____________________________________________________________________________
Home Phone # ________________ Cell Phone # ______________ Work Phone #________________

Spouse’s Name___________________________________________
Social Security Number______________________________ Date of Birth ____________________
Address _____________________________________________________________________________
Home Phone # ________________ Cell Phone # ______________ Work Phone #________________

Name(s) and age(s) of dependents living with you for whom you are responsible. Please include DOB:
  ____________________________________________________  __________________________
  ____________________________________________________  __________________________
  ____________________________________________________  __________________________
**INCOME**

Prior year’s **AGI** (Adjusted Gross Income) reported to the IRS (found on Form 1040) __________________________

*If you did not file a tax return, please explain* __________________________________________________________

Current Employer ____________________________________________________________

Address ____________________________________________________________________________

Phone Number ____________________________ Occupation __________________________

Length of Employment _______ years _______ months Full Time / Part Time _________________

Number of hours scheduled to work each week ____________

If unemployed, date of unemployment: __________ Are you receiving unemployment Yes / No ______

If YES – Beginning date______________________ Amount receiving weekly_______________

Spouse / Significant Other’s Current Employer ____________________________________________

Address ____________________________________________________________________________

Phone Number ____________________________ Occupation __________________________

Length of Employment _______ years _______ months Full Time / Part Time _________________

Number of hours scheduled to work each week ____________

If unemployed, date of unemployment: __________ Are you receiving unemployment Yes / No ______

If YES – Beginning date______________________ Amount receiving weekly_______________

<table>
<thead>
<tr>
<th>Income on a Monthly Basis</th>
<th>Yours</th>
<th>Spouse</th>
<th>Assets</th>
<th>Value/Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Pay</td>
<td></td>
<td></td>
<td>Current Home</td>
<td></td>
</tr>
<tr>
<td>Alimony/ Child Support</td>
<td></td>
<td></td>
<td>Other Property (land, investment, rental, etc.)</td>
<td></td>
</tr>
<tr>
<td>Social Security</td>
<td></td>
<td></td>
<td>Vehicle(s)</td>
<td></td>
</tr>
<tr>
<td>Unemployment / Work Comp</td>
<td></td>
<td></td>
<td>Investments - Stocks, Bonds, Mutual Funds, 401k, IRA, Annuities</td>
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</tr>
<tr>
<td>Retirement / Pension</td>
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<td></td>
<td>Savings Account I.</td>
<td></td>
</tr>
<tr>
<td>Interest / Rental</td>
<td></td>
<td></td>
<td>Savings Account 2.</td>
<td></td>
</tr>
<tr>
<td>Public Assistance</td>
<td></td>
<td></td>
<td>Checking Account</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Monthly Total</td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

(Office use only) **Annual Total** __________________________

---

## EXPENSES

Name of Mortgage Holder or Landlord______________________________________________________________

Address_______________________________________________________________________________________
_______________________________________________________________________________________

<table>
<thead>
<tr>
<th>Monthly Payment</th>
<th>Outstanding Balance</th>
<th>Current Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortgage / Rent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Owner’s / Renter’s Insurance</td>
<td></td>
<td></td>
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<tr>
<td>HOA</td>
<td></td>
<td></td>
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<tr>
<td>Telephone - home</td>
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</tr>
<tr>
<td>Cell Phone</td>
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</tr>
<tr>
<td>Electricity</td>
<td></td>
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<tr>
<td>Gas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cable / Satellite / Dish</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auto Loan</td>
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<tr>
<td>Auto Loan</td>
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<td></td>
</tr>
<tr>
<td>Auto Insurance</td>
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<tr>
<td>Transportation - Gas</td>
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</tr>
<tr>
<td>Life Insurance</td>
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</tr>
<tr>
<td>Health Insurance</td>
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<tr>
<td>Medical Bills</td>
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</tr>
<tr>
<td>Prescriptions</td>
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<td>Food</td>
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<tr>
<td>Child Care</td>
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</tr>
<tr>
<td>School Expenses / Loans</td>
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<tr>
<td>Alimony / Child Support</td>
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<tr>
<td>Credit Card Bills</td>
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<tr>
<td>Internet</td>
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<tr>
<td>Other</td>
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<td></td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Monthly Total</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Office use only) Annual Total__________________________
OTHER

Do you receive food stamps? ☐ Yes ☐ No

Do you have medical benefits? ☐ Yes ☐ No

If no, have you applied for Medicaid? __________ Date Applied_______________________________

If benefits were denied, what reason was given? _________________________________________________
_________________________________________________________________________________________

Date Medicaid was denied _____________________________

REQUIRED DOCUMENTS:

• Completed, signed and dated application
• Copy of your last 3 months of pay stubs for you, spouse and/or significant other
• 3 months bank statements (includes personal/savings/business accounts, displaying account owner’s name and account number
• Copy of award letter(s) – Unemployment, Social Security, etc. displaying monthly benefit
• Child Support / Court Ordered Maintenance
• Copy of prior year’s tax returns (all pages) must be submitted with this application. Cannot accept W2 forms.
• If unemployed and / or living with friend or family, page three (3) “Expenses” must be filled out

If unemployed and living with family or friend
Page three (3) of the financial application must be completed showing what the monthly mortgage/rent, electric/gas and cable statements reflect. (Please do not provide receipts)

If Applicant of Spouse is self-employed:
Must provide copy of the business ledger for the last three (3) months

Non-US Residency
Provide a copy of your photo ID. Passport, Visa, etc.

We will deny applications that are incomplete.

Your signature is required to complete this application.
My signature attests that the information I have provided on this form is accurate and true to the best of my knowledge. I understand that SCL Health System requires verification of income before any determination is made. I also understand that my credit may be accessed, at no expense to me, to verify the above information.

Signature_______________________________________________ Date ____________________________
Please use space below if needed:

_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Office Use Only:

Family Size_____     Income___________ Yearly Expenses___________     Poverty Level___________

Out Pt. Responsibility___________ In Pt. Responsibility ___________    Clinic Responsibility__________ Level:_______

Special Notes: ______________________________________________________

_________________________________________________________________________________________________
_________________________________________________________________________________________________

_________________________________________________________________________________________________

Financial Coordinator Name: ___________________________________________     Approved     Denied
Decision Date ________________________________