Thank you for your interest in our Financial Assistance Program. If you and/or a family member have applied for financial assistance at Saint Agnes Medical Center within the last six (6) months, please contact our office at (559) 450-3145 or (855) 224-5998 before completing this application.

Please return the completed application and all applicable documents listed below within thirty (30) days:

- ☐ **Three (3) months complete, itemized bank statements for all checking, savings, and/or investment accounts showing deposits and withdrawals. Please provide explanation for all deposits. (Required)**

- ☐ **Proof of earned and/or unearned income as documented below. (Required)**

1. Three (3) recent pay stubs for yourself, spouse and all dependents showing pay rate and hours worked OR
2. Current, or most recently filed, federal tax return for yourself and spouse OR
3. Contribution statement from family/friends stating how living expenses are being met AND
4. Any of the following documents, as applicable for yourself, spouse and all dependents:
    - Most recent tax return including Profit/Loss statement if self-employed
    - Most recent tax return for verification of dependents
    - Unemployment benefits statement
    - Student financial aid award letter
    - Determination letter for public assistance (e.g., CalFresh, Medi-Cal, etc.)
    - Social Security and/or Social Security Disability award letter or check
    - Dividend, interest and income from any other source (e.g., rental income, alimony income, retirement benefits, etc.).

If you are unable to provide any of these documents, please provide a letter of explanation as to why the documents were not returned.

Please return the financial assistance application and supporting documents to:

Saint Agnes Medical Center
Patient Business Services - Financial Services
34375 W 12 Mile Rd
Farmington Hills, MI 48331

Return by: ______________

Please allow approximately 30 days for processing once we have received a completed application. If you have any questions or require information in another language, please contact our office at the number listed below.

Sincerely,

Saint Agnes Medical Center
Customer Service
(559) 450-3145 or (855) 224-5998

NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

Saint Agnes Medical Center, honor the sacredness and dignity of every person, complies with applicable Federal Civil Rights laws, and does not discriminate on the basis of protected classes, including but not limited to, race, color, national origin, age, disability or sex.

Saint Agnes Medical Center: Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language and interpreters services through video and audio interpreter system network.
- Written information in other formats such as large print, audio, accessible electronic and other formats.

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters services
- Information written in other languages

If you need these services, please contact us at (559) 450-3000 TTY (559) 450-3233 for assistance

If you believe that Saint Agnes Medical Center has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance in person, by mail, fax or email to:

Saint Agnes Medical Center,
Attn: Risk Management
1303 E. Herndon Ave.,
Fresno, CA 93720
559-450-7475,
Email: Information@samc.com

You can also file a civil rights complaint with the US Department of Health & Human Services, Office of Civil Rights electronically via web, by mail or phone to :

Department of Health & Human Services
200 Independence Avenue, SW, Room a509F,
HHH Building, Washington, DC 20201
Web https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Phone 1-800-368-1019 TTY 1-800-537-7697

Saint Agnes Medical Center

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-559-450-3000 (TTY: 1-559-450-3233).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-559-450-3000 (TTY: 1-559-450-3233).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-559-450-3000 (TTY: 1-559-450-3233).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-559-450-3000 (TTY: 1-559-450-3233).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.)번으로 전화해 주십시오. 1-559-450-3000 (TTY: 1-559-450-3233).

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-559-450-3000 (TTY: 1-559-450-3233).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните . 1-559-450-3000 (TTY: 1-559-450-3233).

Hindi

ध्यान द: यद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह।) पर कॉल कर।1-559-450-3000 (TTY: 1-559-450-3233).

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます）まで、お電話にてご連絡ください。1-559-450-3000 (TTY: 1-559-450-3233).

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le . 1-559-450-3000 (TTY: 1-559-450-3233).

Panjabi

ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।) 'ਤੇ ਕਾਲ ਕਰੋ।1-559-450-3000 (TTY: 1-559-450-3233).

Portugese

Saint Agnes Medical Center

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para . 1-559-450-3000 (TTY: 1-559-450-3233).

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: . 1-559-450-3000 (TTY: 1-559-450-3233).

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
1-559-450-3000 (TTY: 1-559-450-3233 فراهم می باشد. با تماس بگیرید

Cambodian

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល
គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ ។ 1-559-450-3000 (TTY: 1-559-450-3233).

Thai

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-559-450-3000 (TTY: 1-559-450-3233).

Lao

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ,
ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-559-450-3000 (TTY: 1-559-450-3233).

Arabic

) - ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1
.- هاتف الصم والبكم: 11-559-450-3000 (TTY: 1-559-450-3233).

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 559-450-3000 (TTY: 1-559-450-3233).

Samoan

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-559-450-3000 (TTY: 1-559-450-3233).

Hawaiian

E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo [hoʻokomo ʻōlelo], loaʻa ke kōkua manuahi iā ʻoe. E kelepona iā 1- 1-559-450-3000 (TTY: 1-559-450-3233).

CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE

Professional services provided by affiliated physicians or other providers may be billed separately. Application of Financial Assistance is at the discretion of those providers in accordance with their policies, procedures, and applicable regulations. The information provided in this application may be provided to affiliated providers to assist the patient. Saint Agnes Medical Center honors the sacredness and dignity of every person, complies with applicable federal and state laws, and does not discriminate on the basis of protected classes, including but not limited to, race, color, national origin, age, disability or sex.

Patient Name		Date of Birth
Street Address		Telephone	Message Phone
City/State/Zip		Social Security Number
Mailing Address (if different) or email if preferred		

Please provide the following information for yourself (if not the patient), spouse and dependents:

Name	SSN	Date of Birth	Relationship to Patient

Please list all account numbers and/or dates of service to be considered for financial assistance:

Patient Name	Account #	Date of Service	Medical Balance

Healthcare Marketplace Status

Have you applied for Insurance?	□ No	□ Yes	If Yes, Name/ID
If Yes, did you apply through:			□ Medicaid - State □ Health Exchange/ Healthcare.gov □ Other ______________________
Were you approved for an insurance plan?	□ No	□ Yes	
Have you enrolled and paid the premium for an insurance plan?	□ No	□ Yes	

Monetary Assets

Checking Account Balance	Bank:	$
Savings Account Balance	Bank:	$

Employment

Person Employed	Employer	Gross Pay Period	# of Pay Periods	Annual Gross
		$		$
		$		$
		$		$
		$		$

Other income Source	**Monthly**	**Annually**
Alimony	$	$
Public Assistance Program Type ________________ (e.g., Cash, Food Stamps, etc.)	$	$
Payment from Retirement Plan	$	$
Social Security / Social Security Disability	$	$
Unemployment or Worker's Comp No. of Weeks:__________ Start Date:__________ End Date: __________ Per Week $:_______________	$	$
Other Income (Stocks/Bonds/Annuities/Interest/Rental Property)	$	$
Other Income (from family, friends, church, etc…)	$	$

VERIFICATION OF INCOME AND IDENTIFICATION

If we need additional information, you will be notified by telephone, US Mail or e-mail.

I certify that all information is true and complete to the best of my knowledge. I understand that the information provided will be verified and treated as personal and confidential. I authorize the release of any and all information from the California Department of Health Care Services. **I understand that I must provide verification of income, expenses, dependents, bank statements, pay vouchers and tax statements if applicable.** I also understand that I will be liable for payment of any services rendered at Saint Agnes Medical Center if the above information is given under false pretenses. I know that I am asking for financial assistance from Saint Agnes Medical Center only and not from other health care providers or physicians.

SIGNATURE: ____________________ **DATE:** ____________________

SPOUSE SIGNATURE (if applicable) ____________________ **DATE:** ____________________