[CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE OR DISCOUNTED PAYMENT]

For Hospital and Professional services provided by facilities and physicians of Trinity Health]

Personal & Confidential

Thank you for selecting *Saint Agnes Medical Center* as your health care provider. Please complete the enclosed application and return to the address below to complete the evaluation of your discounted payment or financial assistance. See grid below:

Trinity Health West Region
2024 Federal Poverty Level (FPL) & Charity Adjustment Guidelines For West Region Residents

	100%	138%	200%	201%	300%	350%	400%
Family Size	Income	Income to:	Income to:	Income to:	Income to:	Income to:	Income over:
1	$15,060	$20,783	$30,120	$30,271	$45,180	$52,710	$60,240
2	$20,440	$28,207	$40,880	$41,084	$61,320	$71,540	$81,760
3	$25,820	$35,632	$51,640	$51,898	$77,460	$90,370	$103,280
4	$31,200	$43,056	$62,400	$62,712	$93,600	$109,200	$124,800
5	$36,580	$50,480	$73,160	$73,526	$109,740	$128,030	$146,320
6	$41,960	$57,905	$83,920	$84,340	$125,880	$146,860	$167,840
7	$47,340	$65,329	$94,680	$95,153	$142,020	$165,690	$189,360
8	$52,720	$72,754	$105,440	$105,967	$158,160	$184,520	$210,880
Additional Persons, add	$5,380	$7,424	$10,760	$10,814	$16,140	$18,830	$21,520
Charity Write-off Fresno	100%	100%	100%	76.8%	76.8%	76.8%	0%
Uninsured Discount	40%	40%	40%	40%	40%	40%	40%

Note patients who only apply for discount payment may received less financial assistance than what may be available under the Saint Agnes Charity Adjustment Guidelines.

If you have any questions, please contact our Customer Service Center at 800-494-5797, Monday through Friday between 9:00 a.m. - 5:00 p.m. ET.

Sincerely,

Trinity Health Enterprise Patient Financial Services
On behalf of *Saint Agnes Medical Center*
20555 Victor Parkway
Livonia, MI 48152

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[Please complete and sign application form and return within 10 days including copies of the following:]*

[Required Verifications]

☐ Past One month Proof of Gross Income]

☐ [Recent Tax Returns (1040 form with Schedule C, E or F) or Three Months Profit and Loss Statements (for self-employed/dependents)]

[Provide the following, If applicable]

☐ [Recent W2 for Seasonal Income] ☐ [Unemployment Benefit/ Denial letter] ☐ Child Support Income/Alimony]

☐ [No Income – Complete Letter of Financial Support portion of the application]

☐ Past Two months Complete Bank Statements for all bank accounts, with all pages included (explanation for recurring deposits)]

***NOTE: For patients applying only for a discount payment, only prior paystubs and income tax returns will be required to verify income.**

Patient Information

[Patient Name]		[Date of Birth]	
[Social Security/EIN Number (optional)]	Mobile Phone]	[Other Phone]	
[Mailing Address]	[City]	[State]	[ZIP code]
[Email Address]	[Of what state are you a resident?]		
[Marital status] □[Single] □[Married] □[Divorced] □[Other] _____			
[Do you file a Federal Tax Return?] □ [Yes] □ [No] [If no, why?]	[Can you be claimed as dependent on someone else's tax return?] □ [Yes] □ [No]		
[Did you or your dependents have health insurance coverage at the time of service? □ [Yes] □[No] [(Provide Insurance card copy)			
[Are you a documented resident of the United States? □ [Yes] □ [No] □ [Prefer Not to Answer]			

[Household Members, including yourself based on your recent Tax Returns]	[Date of Birth]	[Relationship to Patient]	[Claimed on Tax Return (Yes/No)]

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[Income Verification for all household members]

[Monthly Income Source]	[Who receives this?]	[Gross Monthly Income (before taxes)]	[Monthly Income Source]	[Who receives this?]	[Gross Monthly Income (before taxes)]
[Wages]			[Worker's Compensation]		
[Social Security/Disability]			[Unemployment]		
[Pension]			[Child Support/Alimony]		
[Self-Employment]			[Rental Land Income]		
[Public Assistance]			[Other]		

[Letter of Financial Support - Should only be completed by the person providing support]

☐ [I provide more than 50% support for the patient's living expenses, but I am unable to help with medical bills.]

☐ [By signing this letter, I verify that the above statement is correct and that I will in no way be held liable for the patient's bills. If you have questions, please contact me at _____ (Phone Number)]

[Name of person providing support]	**[Relationship to Patient]**
[Signature of person providing support]	**[Date]**

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[VERIFICATION OF INCOME AND IDENTIFICATION]

[I certify that the information listed in this application is true and complete to the best of my knowledge. I understand that the information provided is subject to verification. I will be responsible for repayment of any services provided at Trinity Health affiliates if the above information is provided under false pretenses.]

[Signature of Patient]: _____[Date]: _____

[Or Signature of Legal Guardian (If Applicable)]: _____[Date]: _____

[Relationship to Patient]: _____[Date]: _____

[Please mail your application to the address above, fax at 312-871-3350 and or upload documents through MyChart (Patient Portal) - https://mychart.trinity-health.org/MyChart If you have any questions, please contact our Customer Service Center at 1-866-626-7272 Monday through Friday 9 a.m. -5 p.m. ET.]