St. John's Hospital Foundation Patient Assistance Fund Application

Please note that all sections of this application must be completed to be considered for support.

Name: _____

Mailing Address: _____

Phone: _____ Date of Birth: _____

Referral Source: _____ Physician(s): _____

Name of Insurer: _____ Deductible Amount: $ _____

Have you applied for insurance? **YES / NO** Would you like assistance applying for coverage? **YES / NO**

Type of insurance: Medicaid / Medicare / Employer / Marketplace / Disability / Self-Pay / None / Other

What is the total amount of your request? $_____

Briefly explain the nature of your needs at this time (e.g., preventive care, doctor's visit, screening, medication, travel, lodging, food, fuel, childcare, etc.).

_____

_____

_____

_____

Have you completed a Patient Assistance application at St. John's Medical Center: **YES /NO**

Have you received financial support from any of the Foundation's Patient Funds in the past? **YES/NO**

Please list the names of all other agencies or resources you have contacted for assistance:_____

By signing this agreement, I understand that my information, including protected health information will be shared with outside agencies and the people necessary to translate, determine medical necessity, and to make a determination of coverage for the program and I agree to allow all necessary disclosures. I also consent to a soft credit check. This will not affect your credit score, but will impact your award.

Signature of applicant:_____Date: _____

Printed name: _____

Signature of SJMC Representative:_____Date: _____

Please attach any additional information and return your completed application to Jen Simon or call 307.739.7529 for assistance.