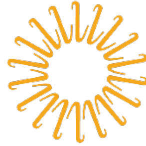

Coastal Medical

Lifespan. Delivering health with care®

Dear Coastal Medical Patient,

In the event you are seeking financial assistance, please fill out the enclosed financial assistance application. With the application, you will find a checklist of required documents for the application to be processed by a Patient Financial Advocate. Please provide all documents with the completed application.

Please mail the application and supporting documentation directly to the Patient Financial Advocates Office at Rhode Island Hospital (see mailing address below). Applications are processed within 14 days of receipt if all required informed is received. If all required information is not received, the Patient Financial Advocate will notify you of the missing documentation by phone call and will mail a list of missing documentation.

If you have questions regarding the application and checklist, please call **401-444-7850**.

Mailing Address:

Rhode Island Hospital
593 Eddy St
Providence, RI 02903
Attn: Patient Financial Advocate – Main Admitting

Thank you for trusting us with your healthcare.

Sincerely,

Your Coastal Medical Care Team

LIFESPAN HOSPITALS AND AFFILIATE FINANCIAL ASSISTANCE APPLICATION

Any approval of this request is temporary and expires 12 months from date of approval

Lifespan Hospitals and Affiliates — Date:

Patient:	Guarantor/Spouse:
MR#:	MR#:
Date of Birth:	Date of Birth:
Social Security # (if issued):	Social Security # (if issued):
Home Phone: Cell Phone:	Home Phone: Cell Phone:
Home Address:	Relation to Patient:
	Home Address:
Own/Rent?	
Occupation & Employer:	Occupation & Employer:
Employer Address:	Employer Address:

Is this visit related to a work injury or accident? Yes No (if yes, please provide insurance information and attach explanation)

Are you being claimed as a dependent? Yes No — Number of Dependents (including self):

Do you collect SNAP benefits? Yes No If yes, provide current letter — Are you living in a shelter? Yes No If yes, provide a letter from shelter

Have you applied to HealthSource RI? Yes No please provide letter — Have you applied for Social Security Disability? (SSDI) Yes No (if yes, when)

Please provide the following information for ALL members of the family unit, EXCEPT the Patient or Guarantor.

Name & Relationship to Patient:	SS# (if issued):	Date of Birth:	MR#:
Employer, Phone & Address:	Home Address:		
Name & Relationship to Patient:	SS# (if issued):	Date of Birth:	MR#:
Employer, Phone & Address:	Home Address:		
Name & Relationship to Patient:	SS# (if issued):	Date of Birth:	MR#:
Employer, Phone & Address:	Home Address:		
Name & Relationship to Patient:	SS# (if issued)	Date of Birth:	MR#:
Employer, Phone & Address:	Home Address:		

MONTHLY INCOME	AMT	ASSETS	AMT	MONTHLY EXPENSES/LIABILITIES	AMT
Patient's Salary & Wages		Savings		Mortgage or Rent Payment	
Spouse's Salary & Wages		Checking		Current Balance ______________	
Guarantor's Salary & Wages		Certificates of Deposit (CDs)		Property Taxes if not included in mortgage payment	
Self-Employment Income		Money Market Accounts		Utilities: Gas/Electric/Oil _______	
Child Care Income		Savings Bonds		Cable/Internet _______	
Rental Income		Stocks		Phone _______	
Unemployment Compensation		Bonds		Auto Payments or Lease Payments	
Temporary Disability Insurance		Mutual Funds		Current Balance ______________	
Child Support		IRAs		Credit Card Payments	
Alimony		401(k)s		Current Balance ______________	
VA Benefits		403(b)s		Installment Loans	
Social Security Payments		457s		Current Balance ______________	
Dividend & Interest Income		Cash-In Value Life Insurance		Auto Insurance	
Royalties		Personal Property		Homeowners/ Renters Insurance	
Pensions		2nd Home & Rental Property		Medical Expenses	
Public Assistance (*include SNAP if receiving*)		Additional Motor Vehicles		Groceries	
Other				Other Expenses	
MONTHLY INCOME:					
ANNUAL INCOME:		TOTAL:		TOTAL:	

"I request the hospital to make a determination of eligilibility for financial aid. I understand that this information is confidential and subject to verification by the hospital. I also understand that if the information I provide is false, I may be denied financial aid and be liable for payment for the hospital services provided. I hereby attest that the information in this application is complete and correct to the best of my knowledge and that I understand the process and my responsibilities."

Patient's Signature: ______________________________ Date: ______________

Spouse/Guarantor Signature: ______________________________ Date: ______________

FOR INTERNAL PURPOSES ONLY

Approved By: ______________________________ Date: ______________

Denied By: ______________________________ Date: ______________

Manager Signature: ______________________________ Medical Assistance: ❒ Yes ❒ No

Insurance Coverage: ______________________________

Comments: ______________________________

____

Family Size: ____________ FPL Level: ____________ %FPL: ____________

DISCOUNT (%): ____________ Date Range: ______________________________

Financial Assistance Checklist

Patient Name: MRN:
Today's date:

- [ ] **Identification – Any of the following**: a state-issued driver's license, a state-issued ID card, Passport, Alien Card, etc.

- [ ] **Proof of residence: Copy of utility bill in your name** (*if living with others: utility bill of person providing shelter with letter verifying address).* **If you are homeless, you may provide a letter from a shelter or family/friend verifying address.**

- [ ] **List of monthly expenses on a sperate piece of paper** (Heat, Rent, Food- Utilities, etc.)

- [ ] **A signed copy of your most recent income tax return.** (*If you did not file a tax return, a copy of an IRS Non-Filing letter stating that you did not file a tax return. The letter can be obtained by calling 1-844-545-5640*

- [ ] **Copies of most recent pay stubs** *(at least two (2) consecutive pay periods)* **for all family members who are employed.**

- [ ] **Copies of statements of income such as Child Support, Accident/Workers Comp. Settlements, Unemployment, Temporary Disability (TDI), Social Security (SSI/SSDI), Pensions, Rental Property and/or Food Stamp Eligibility Letter, etc.** *(If no income, a letter of support from person who is supporting you financially.)*

- [ ] **Current copies of statements for all accounts: Checking, Savings, CD's, IRA, 401K's and Money Markets. If self-employed, the last three statements for Checking/Savings accounts are required.** *(If no Checking, Savings, CD's, IRA, 401K's or Money Markets, a letter stating such.)*

- [ ] **Other:**

Please return your documentation in the enclosed posted paid envelope. If you have any questions, please call the Patient Financial Advocate listed below:

Sincerely,

Karen Mendez - 401-444-3496
Rhode Island Hospital
593 Eddy St
Providence RI, 02903