**CONFIDENTIAL APPLICATION FOR HOSPITAL CARE ASSURANCE PROGRAM (HCAP) or FINANCIAL ASSISTANCE**

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

**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 ☐ Past Three months Proof of Gross Income (if applying for HCAP)

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

☐ 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

**Patient Information**

| | | | |
|---|---|---|---|
| Patient Name | | | Date of Birth |
| Social Security/EIN Number (optional) | Mobile Phone | Other Phone | |
| Mailing Address | City | State | Zip code |
| Email Address | What state are you a resident of? | | |

Marital status Single ☐ Married ☐ Divorced ☐ Other ☐ _____

Date (s) of Hospital service: From _____ To _____

| | |
|---|---|
| Do you file a Federal Tax Return? ☐ Yes ☐ No<br>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 | Income for 3 months prior to hospital service | Income for 12 months prior to hospital service | Claimed on Tax Return (Y/N) |
|---|---|---|---|---|---|
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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 support provider**

☐ 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 supporting** | **Relationship to Patient** |
|---|---|
| **Signature of person providing support** | **Date** |

**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: _____Date: _____
(If Applicable)

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 800-494-5797 Monday through Friday 9 AM-5 PM EST.**

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