

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

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

Personal & Confidential

Guarantor Name Smarttext

Guarantor Address Smarttext

Date Smarttext: October 08, 2021

**Guarantor:** Guarantor smarttext

**Case Number:** smarttext

**Patients Included in Case:**

- smarttext patient name(s)

Dear patient name smarttext,

Thank you for selecting RHM smarttext as your health care provider. Please complete the enclosed application and return to the address below to complete the evaluation of your financial assistance.

If you have any questions, please contact our Customer Service Center at 800-494-5797 Monday through Friday between 9:00 am - 5:00 pm EST.

Sincerely,

Trinity Health Enterprise Patient Financial Services

On behalf of RHM smarttext

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  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? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why?	Can you be claimed as dependent on someone else's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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)
(Patient)		self			

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<b>Income Verification for all household members</b>					
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		
<b>Letter of Financial Support - Should only be completed by support provider</b>					
<input type="checkbox"/> I provide more than 50% support for the patient's living expenses, but I am unable to help with medical bills.					
<input type="checkbox"/> 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)					
<b>Name of person supporting</b>				<b>Relationship to Patient</b>	
<b>Signature of person providing support</b>				<b>Date</b>	

**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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