Financial Assistance Cover Letter

Thank you for choosing St. Tammany Health System for your health care needs. We provide the best customer service possible to our patients and families.

Enclosed is a Financial Assistance application for your completion. The information you provide will be used to determine whether you qualify for any type of financial assistance with the account balances owed to St. Tammany Health System.

It is very important that you complete all sections of the application. An incomplete application may forfeit our consideration of potential assistance. Please enter “none” or “not applicable” in any blank that does not apply to you.

In addition to completing the application, please attach copies (not originals) of the following.

- Most recent signed Federal Income Tax Return (if you did not file taxes, please indicate why).
- Last 60 days paycheck stubs (if married, spouses’ income documentation is required also).
- Last 2-month bank statements – checking & savings (all pages).
- If you are retired or disabled, most recent Social Security SAS – 1099 form.
- If you have applied for and been denied Medicaid and/or SSI, include denial letter.
- Hardship letter.

This completed application and all requested information must be returned within 30 days of receipt to STHS, Attn: PACS, 1202 S. Tyler St., Covington, La 70433. If you have any questions about the application process, please do not hesitate to contact us at (985) 898-4451. Thank you for your prompt attention and response.

Sincerely,

Patient Financial Services
St Tammany Health System

Financial Assistance Application

Guarantor's Personal Application

Name:			
Address:			
Telephone: Cell/Home		**Work:**	
Guarantor Email Address			
Date of Birth		**Marital Status**	
Employer		**Occupation**	
Spouse/Legal Guardian's Name		**Date of Birth**	
Spouse's Employer		**Occupation**	

Patient's Information (if other than guarantor)

Name:		**Relationship to Patient**	
Address (if different than above):		**Date of Birth**	
Telephone: Cell/Home		**Work:**	
Email Address			

If you are presently unable to work due to medical conditions, when will you return? _____

Have you applied for Medicaid? _____ SSI? _____

Note: if you were denied Medicaid or SSI, attach denial letter to this application.

Dependents (as defined by IRS rules).

Name	Relation	Age
1.		
2.		
3.		
4.		
5.		

Financial Statement

Household Income

Salary, Wages	
Social Security	
Other Retirement Income	
Disability	
Veteran's Income	
Investment Income	
Unemployment Income	
Rental Income	
Other Income (describe)	
Total Monthly Income	

For Hardship Application Only

Monthly Expenses

Rent/Mortgage	
Credit Cards	
Telephone	
Electric & Gas	
Water	
Auto Payment	
Insurance	
Other (describe)	
Total Monthly Expense	

Note: Attached documentation must support the information provided.

I certify that the information on this application is complete and accurate.

_____ _____

Signature Date

Please return this completed application using one of the following methods:

- **Email**: patientcustomerservice@stph.org Fax: 985-898-4358
- **Hand Delivery**: Cashier's Office in the hospital main lobby

- **U.S. Mail**: STHS Attn: PACS
1202 S. Tyler Street Covington, La 70433