PRESBYTERIAN

Financial Assistance Application

If you need help to complete this form, please ask to speak with one of our Financial Counselors or call Customer Service toll free 1-800-251-9292 or locally at 505-923-6600.

Name of PHS Facility_____ Patient Name_____ Account Number_____

Instructions for completing this form:

This completed form should be attached to the required documentation and returned to PHS Patient Accounting to be processed.

- Prior year's tax return(s)
- Minimum of two most recent pay stubs

Responsible Party Name_____ Last 4 digits of Social Security #_____ Date of Birth_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Other Responsible Party Name_____ Last 4 digits of Social Security #_____ Date of Birth_____

Cell Phone_____ Relationship to patient_____

Employer_____ Work Phone_____

Gross monthly/annual income $_____

Additional Household Members

Name	DOB	Relationship	Name	DOB	Relationship

Persons who apply for financial assistance are required to first explore other sources of funding. Please indicate which sources you have applied for and the reasons you are not eligible for this assistance.

- ❑ Group health insurance _____
  Does your employer offer group health insurance yes/no
- ❑ Medicaid- if denied, please attach a copy of the Medicaid denial
- ❑ Other state or county assistance (Sole Community, Indigent)
- ❑ Other third-party programs (homeowners, auto etc.)
- ❑ Cobra Coverage

Signature required on back of form

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Describe inability to pay account balance: (additional documentation may be required)

_____
_____
_____
_____
_____

If you do not have the required documentation listed, please inquire as we may be able to accept alternative documentation to satisfy this requirement. Patients who fail to follow through in the application process, or who refuse to apply for outside programs and who potentially may have qualified, may be denied financial assistance.

I hereby state that the information given herein is true and correct. I authorize any required verification, including credit bureau report. I understand that if this information is determined to be false or deceptive, I will be liable for payment of charges for all services rendered. I understand that this request for financial assistance does not pertain to other healthcare providers.

Please return completed application and required documentation to or you can fax it to (505) 923-6698:

Presbyterian Healthcare Services
Attention: Patient Accounting
PO Box 26268
Albuquerque, NM 87125

Applicant Signature_____ **Date**_____

Presbyterian is committed to protecting the confidentiality of its patients. Any information provided by individuals to Presbyterian through the financial assistance application process will remain confidential, will only be used by Presbyterian for its internal purposes, and will not be released to any third parties outside of the Presbyterian system without the express consent of the individual.

For Internal Use Only:

Account Number	*Facility*	*Amount*	*Account Number*	*Facility*	*Amount*

Approved_____ **Date**_____

- ❑ 50% assistance
- ❑ 75% assistance
- ❑ 100% assistance

Denied_____ **Date**_____

- ❑ Income greater than 400% of the federal poverty level
- ❑ Documentation not received