CATHOLIC HEALTH SERVICES
Verification Letter

Dear Applicant:

Thank you for your interest in the financial assistance program offered by Catholic Health Services. Our facilities will bill all insurance or approved State/Federal Programs for medical and other services rendered to any insured patient/resident. If you have no health insurance coverage and the services are not covered under any existing Federal, State or Local Assistance Programs, you may be eligible for a discount provided the debt for which you are being billed does not represent a routine deductible or co-pay amount after an insurance payment. **In these cases, special consideration may be given for co-pay or deductible amounts upon receipt of a hardship letter from you or your representative.** In addition, elective services that are included under established self-pay contracts are excluded from any further discounts, as well as services rendered that are deemed medically unnecessary.

The above also applies to rents and tuition assistance requests.

PLEASE PROVIDE DOCUMENTATION REFLECTING TOTAL HOUSEHOLD INCOME FOR ALL EMPLOYED ADULTS ALONG WITH THE COMPLETED FINANCIAL ASSISTANCE APPLICATION.

1. Complete 1040 tax return with the W-2 form from the previous year. (If self employed please include profit and loss statement.).

2. Unemployment Compensation Determination Letter.

3. Three current and consecutive pay stubs for all employed household members and covering all employers.

4. Letter from your employer on company letterhead noting the hourly rate and weekly hours if you cannot provide a current tax return.

5. Social Security check, pension check or yearly Determination Letter if you are retired.

6. Worker's Compensation Determination Letter or a copy of your check.

7. A notarized letter must be provided if you receive child support, receive room and board from a relative, friend, sponsor or, to explain how you are supporting yourself.

8. If you are experiencing a medical or financial hardship and you are seeking financial assistance for your routine co-pay or deductible amounts please provide a detailed description of the situation along with the supporting documentation.

9. Proof of full-time status including documentation of patient's income if the student is listed as a dependent.

10. Record of assets (stocks, bonds, rental property, bank accounts, etc.)

Please review the list above and supply the documentation that applies only to you or your household. Please return the Financial Assistance Application with the verification to your facility's Business Office within 15 days. Should you have any questions, please contact the facility Business Office between the hours of 9:00 am and 5:00 pm.

Thank you.