***Exclusions include, but are not limited to**: Cosmetic, bariatric procedures, sterilization reversal, erectile dysfunctions, accounts indicating third party involvement or accounts that are 240 days or more past the first hospital statement date will not be considered for Financial Assistance.*

REQUEST FOR FINANCIAL ASSISTANCE OR MEDICAL INDIGENCY

Thank you for requesting information regarding our Financial Assistance program, which would provide assistance for Roper Hospital, Bon Secours St. Francis Hospital, Mount Pleasant Hospital, Roper Berkeley and the Roper St. Francis Physician Partners only. You must complete the instructions below in order for your application to be considered.

All applicants 18 years of age or older must sign their application.
Otherwise, a Power of Attorney will be required.

PLEASE SEND COPIES ONLY OF ALL INFORMATION BELOW IF IT IS APPLICABLE TO YOUR HOUSEHOLD INCOME
Note: Household income includes Patient and Spouse (if married)

Send proof of assets:

- Send copies of your most recent months of bank statements for all accounts (full statement not the transaction history)

Send proof of income that applies to your household; (*examples listed below)*

- Current Social Security Benefits Letter
- Current pay stubs – 12 weeks
- Alimony & Trust
- Annuities, Pensions, Retirement Benefits
- Disability Income
- Workers' Compensation Income
- Unemployment Benefits
- Student Loan Disbursements
- Unreported Income
- Most recent tax return for self-employment

If visiting the U.S. from another country, send proof of current tourist, work or student visa (green card) or Passport.

Please return the fully completed, signed application with required documentation to Patient Financial Services:

Mail to: Roper St. Francis Mount Pleasant Hospital
PO Box 602441
Charlotte, NC 28260-2441

Fax: 843-402-2036
Email: RSFFinancialAssistance@rsfh.com

Failure to provide the requested information may result in delays and possibly a denial.

If you have difficulty completing the attached form or have questions please contact 888-888-7010 or 843-402-5200, Option 3, Monday through Friday, 9:00 am to 5:00 pm. We will make every effort to process the application within 30 days of receipt and notify you in writing of the outcome of your financial assistance request.

If this information is not received, the account balance(s) will remain billable to the responsible party

ROPER ST. FRANCIS HEALTHCARE

Financial Assistance Application

Name:		**Account Number:**
Address:		
City:	**State:**	**Zip Code:**
Phone:		**SSN:**

HOUSEHOLD INFORMATION: Please list all members of the household, including patient, spouse and any biological/legally adopted children under 18 years old

First and Last Name	Relationship to Patient	Age/DOB	Total Gross Income in the 3 Months Prior to the Date of Service	Total Gross Income in the 12 Months Prior to the Date of Service
	Self			

If you have no income, how you are being supported?

_____

Did you have health insurance on the date of service? ☐ No ☐ Yes (Provide card copy with application)

Does anyone in your household have a checking and or savings account? ☐ No ☐ Yes (Value_____)

Does anyone in your household have any other assets? ☐ No ☐ Yes (Type/Value:_____)

_____

_____

For **Income/Assets** listed above, you must provide the following for each member of the household:

☐ Employment = paystubs showing gross income for 3 or 12 months prior to the date of service

☐ Self Employment = Complete tax forms from most recent filing including Schedule C

☐ Social Security/Pension/Disability = Most recent benefit letter

☐ Other = Proof of any other income (unemployment benefits, dividends, interest, rental income, etc.)

☐ Checking/Savings = Current 30-day statement for each account

By signing this document:
I affirm all the answers on this application are true. Should a subsequent review reveal that any information provided was fraudulent, the decision to provide financial assistance may be reversed and the responsible party will be billed.
I understand that the information I submit is subject to verification and review by federal and/or state agencies and others as required.

Patient Signature:_____ **Date:** _____

Roper St. Francis Healthcare
PO Box 602441
Charlotte, NC 28260-2441
RSFFinancialAssistance@rsfh.com