Financial Assistance Application

How to Apply . . .

In order for us to process your application, you must submit ALL of the documents listed below. Any additional documents requested must be received in the Patient Financial Services department within 15 business days. The information received will remain confidential. **The collection process will continue until your financial assistance status is determined.**

Required Documents:

- ☐ The completed and signed financial assistance application.
- ☐ A complete copy of your signed prior year's federal income tax return.
- ☐ A copy of the SSA 1099 form if retired and/or on Social Security.
- ☐ If employed, copies of four current, consecutive paycheck stubs for patient and spouse. If Self-employed, a copy of the federal tax form schedule C.
- ☐ A copy of the State Assistance program decision notice. (AHCCCS, Medi-Cal or Medicaid).
  NOTE: *"Failure to provide information or failure to participate in the interview" is not acceptable and cannot be used in this application.*

Completing the application is not a guarantee you will be approved for the Financial Assistance Program. Approval is based on verified annual household income and family size in accordance with the expanded Federal Poverty Level guidelines established by the Centers for Medicare (CMS).

Once your application has been reviewed, a letter of determination will be sent.

Please feel free to contact us if you need further assistance. You may call us at (480) 684-7414 or toll free 1 (855) 244-7460 or visit in person at Banner Health 525 W. Brown Rd, Mesa AZ 85201, Monday through Friday, 8:00 a.m. to 5:00 p.m.

Thank you.

Financial Assistance Department
Banner Health, Patient Financial Services

Financial Assistance Application

Please fill out all pages completely and print clearly.

Completing the application is not a guarantee you will be approved for financial assistance and our collection process will continue.

Return the signed and dated application to:
Banner Patient Financial Services
PO Box 18 Phoenix, AZ 85001

Patient Information

Facility: _____ Account Number(s): _____

Patient Name: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone number: _____ Contact Phone number: _____

Assistance Requested By: _____ Relationship to Patient: _____

Spouse Information

Guarantor Name: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone number: _____ Contact Phone number: _____

_____

Household Information

Please list all household members including yourself.

Name	Relationship	Age	Dependent
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

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Banner Patient Financial Services
PO Box 18 Phoenix, AZ 85001

I hereby request that Banner Health consider my request for financial assistance. I understand all disclosed income information is for the sole purpose of determining my eligibility for financial assistance and will be kept confidential.

Should I become eligible to receive any third-party funding I am obligated to report this and my financial assistance eligibility may be reversed.

All of the information which I have provided to Banner Health Hospital Billing Office for myself and on behalf of my family
is true and correct to the best of my knowledge. I further understand that if any of the information is found to be false, my financial assistance application may be denied.

Print name: _____

Signature: _____ Date: _____

Additional Patient Comments

Comments: _____

_____

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