

保密经济援助申请

**[CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE]**

适用于由 Trinity Health 机构和医生提供的医院和专业服务

[For Hospital and Professional services provided by facilities and physicians of Trinity Health]

个人保密信息

Guarantor Name Smarttext

Guarantor Address Smarttext

Date Smarttext: October 08, 2021

保证人: Guarantor smarttext

案例编号: smarttext

案例所涉患者:

- smarttext patient name(s)

尊敬的 patient name smarttext:

感谢您选择 RHM smarttext 作为您的医疗服务提供者。请填写随附的申请表，并按以下地址寄回，以完成对您的经济援助的评估。

如有任何疑问，请在美国东部时间周一至周五上午 9:00 - 下午 5:00 致电 800-494-5797 联系我们的客户服务中心。

谨此致意！

Trinity Health Enterprise Patient Financial Services

代表 RHM smarttext

20555 Victor Parkway

Livonia, MI 48152

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请填写并签署申请表，并在 10 天内连同以下材料的复印件一并寄回：

**[Please complete and sign application form and return within 10 days including copies of the following:]**

所需证明 [Required Verifications]

- 过去一个月的总收入证明 [Past One month Proof of Gross Income]
- 过去两个月所有银行账户的完整银行对账单，包括所有页面（对定期存款的说明） [Past Two months Complete Bank Statements for all bank accounts, with all pages included (explanation for recurring deposits)]
- 最近的报税表（1040 表格及附表 C、E 或 F）或三个月的损益表（自营职业者/受抚养人） [Recent Tax Returns (1040 form with Schedule C, E or F) or Three Months Profit and Loss Statements (for self-employed/dependents)]

如适用，请提供以下材料 [Provide the following, If applicable]

- 最近的季节性收入 W2 [Recent W2 for Seasonal Income]
- 失业救济金/拒绝函 [Unemployment Benefit/ Denial letter]
- 儿童抚养收入/赡养费 [Child Support Income/Alimony]
- 无收入 - 填写申请表中的“资助信”部分 [No Income – Complete Letter of Financial Support portion of the application]

**患者信息 [Patient Information]**

患者姓名 [Patient Name]		出生日期 [Date of Birth]	
社会保障号/ EIN（可选） [Social Security/EIN Number (optional)]	移动电话 [Mobile Phone]	其他电话 [Other Phone]	
通信地址 [Mailing Address]	城市 [City]	州 [State]	邮政编码 [ZIP code]
电子邮件地址 [Email Address]	您是哪个州的居民？ [Of what state are you a resident?]		
婚姻状况（可选） [Marital status (optional)] <input type="checkbox"/> 单身 [Single] <input type="checkbox"/> 已婚 [Married] <input type="checkbox"/> 离异 [Divorced] <input type="checkbox"/> 其他 [Other]			
您是否提交联邦报税表？ [Do you file a Federal Tax Return?] <input type="checkbox"/> 是 [Yes] <input type="checkbox"/> 否 [No] 如果回答“否”，为什么？ [If no, why?]		您能否在其他人的报税表中被列为受抚养人？ [Can you be claimed as dependent on someone else's tax return?] <input type="checkbox"/> 是 [Yes] <input type="checkbox"/> 否 [No]	
您或您的受抚养人在接受服务时是否有医疗保险？ [Did you or your dependents have health insurance coverage at the time of service?] <input type="checkbox"/> 是 [Yes] <input type="checkbox"/> 否 [No]（请提供保险卡复印件） [(Provide Insurance card copy)]			
您是有合法证件的美国居民吗？（可选） [Are you a documented resident of the United States? (optional)] <input type="checkbox"/> 是 [Yes] <input type="checkbox"/> 否 [No] <input type="checkbox"/> 不愿回答 [Prefer Not to Answer]			

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根据您最近的纳税申报表，包括您本人在内的家庭成员 [Household Members, including yourself based on your recent Tax Returns]	出生日期 [Date of Birth]	与患者的关系 [Relationship to Patient]	是否在报税表中申报 (是/否) [Claimed on Tax Return (Yes/No)]

所有家庭成员的收入证明 [Income Verification for all household members]					
月收入来源 [Monthly Income Source]	由谁领取? [Who receives this?]	月总收入 (税前) [Gross Monthly Income (before taxes)]	月收入来源 [Monthly Income Source]	由谁领取? [Who receives this?]	月总收入 (税前) [Gross Monthly Income (before taxes)]
社会保障/残疾 [Social Security/Disability]			工伤赔偿 [Worker's Compensation]		
养老金 [Pension]			失业 [Unemployment]		
自营职业 [Self-Employment]			子女抚养费/赡养费 [Child Support/Alimony]		
公共援助 [Public Assistance]			地产出租收入 [Rental Land Income]		
其他 [Other]					

**资助信 - 仅应由资助者填写 [Letter of Financial Support - Should only be completed by the person providing support]**

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- 我为患者提供 50% 以上的生活费用，但我无法帮助支付医疗账单。 [I provide more than 50% support for the patient's living expenses, but I am unable to help with medical bills.]
- 通过签署此信函，本人确认上述声明正确无误，并且本人绝不承担患者的账单费用。如有疑问，请与我联系： \_\_\_\_\_（电话号码） [By signing this letter, I verify that the above statement is correct and that I will in no way be held liable for the patient's bills. If you have questions, please contact me at \_\_\_\_\_ (Phone Number)]

资助者姓名 [Name of person providing support]	与患者的关系 [Relationship to Patient]
资助者签名 [Signature of person providing support]	日期 [Date]

**收入和身份核实 [VERIFICATION OF INCOME AND IDENTIFICATION]**

我确认，据我所知，本申请表中所列的信息均真实和完整。我理解，提供的信息需要核实。如果上述信息以虚假借口提供，我将负责偿付在 Trinity Health 关联机构提供的任何服务。 [I certify that the information listed in this application is true and complete to the best of my knowledge. I understand that the information provided is subject to verification. I will be responsible for repayment of any services provided at Trinity Health affiliates if the above information is provided under false pretenses.]

患者签名 [Signature of Patient]: \_\_\_\_\_

日期[Date]: \_\_\_\_\_

或法定监护人签名（如适用） [Or Signature of Legal Guardian (If Applicable)]:

日期 [Date]: \_\_\_\_\_

与患者的关系 [Relationship to Patient]: \_\_\_\_\_

日期 [Date]: \_\_\_\_\_

请将申请表邮寄至上述地址，或传真至 312-871-3350，或通过 MyChart（患者门户网站）上传文件 - <https://mychart.trinity-health.org/MyChart> 如果您有任何疑问，请在周一至周五上午 9 点至下午 5 点（美国东部时间）拨打 800-494-5797 联系我们的客户服务中心。 [Please mail your application to the address above, fax at 312-871-3350 and or upload documents through MyChart (Patient Portal) - <https://mychart.trinity-health.org/MyChart> If you have any questions, please contact our Customer Service Center at 800-494-5797 Monday through Friday 9 a.m. -5 p.m. ET.]