ST. FRANCIS
MEDICAL CENTER
601 Hamilton Avenue
Trenton, NJ 08629
(609) 599-5000
Fax (609) 599-5692

Date: _______________

Address: ____

Re: ____

Social Security No: _______________________________

Dear Sir/Madam:

Our Office represents the above mentioned individual. He/She is applying for Charity Care to cover recent medical expenses.

We need to verify his/her ________________ balance for their account(s) with your institution.

Thank you in advance for your cooperation.

Sincerely,

Financial Counselor

____

Balance Date: ________________

Checking #1 $____________
Account # ____________

Savings #1 $___________
Account # ___________

Checking #2 $____________
Account # ____________

Savings #2 $____________
Account # ____________

Other $____________
Account #___________

____
Signature Bank Representative

____
Date

____
Bank Stamp

____
Phone Number