



# National Health Service Corps Financial Care Application

St. Luke's provides financial assistance for qualifying patients who need help paying for some or all emergency or medically necessary care they received in a St. Luke's facility or by a St. Luke's provider. This program was developed to assist low-income, uninsured, or underinsured patients, and those with catastrophic medical bills. Patients who are unable to pay may apply for assistance by completing this application and submitting the requested documents.

Patients who have received services at a National Health Service Corps (NHSC) site or location must provide the following information to determine if they meet eligibility requirements for financial assistance. If you would like to see the list of eligible NHSC sites, you can visit St. Luke's online page: [www.stlukesonline.org/NHSCLocations](http://www.stlukesonline.org/NHSCLocations).

To view our financial care policy and discount guidelines, visit St. Luke's Online: <https://www.stlukesonline.org>.

≤400% GROSS 2026 Federal Poverty Guidelines									
Family Size:	1	2	3	4	5	6	7	8	9
Monthly:	\$5,320.00	\$7,213.33	\$9,106.67	\$11,000.00	\$12,893.33	\$14,786.67	\$16,680.00	\$18,573.33	\$20,466.67
Annually:	\$63,840.00	\$86,560.00	\$109,280.00	\$132,000.00	\$154,720.00	\$177,440.00	\$200,160.00	\$222,880.00	\$245,600.00

## Required Documentation

Please provide documents that apply to your household. Not every item listed is required. Use the checklist below to ensure your application is complete.

### Proof of Income

- Recent pay stubs (last 30 days for all household members over the age of 18)
- Most recent federal tax return with W-2(s)
- If taxes not filed: W-2(s) plus IRS Form 4868 (tax filing extension)
- Other income (disability, unemployment, child/adult support, retirement, rental, dividends, trust income)

### Self-Employed (if applicable)

- Schedule C from most recent tax filing
- 3 months of profit and loss (P&L) statements
- 3 months of Bank statements (Most recent, showing all transactions (deposits and withdrawals) for all accounts)

### Public Assistance (if applicable)

- Documentation of benefits (SNAP/food stamps, cash assistance, unemployment, etc.)
- Social Security Benefit Verification letter

### If you have no income

- A written statement explaining how your household covers living expenses

### Bank Statements

- Only required if used to confirm income or support your application

## Submission Instructions

Please mail, fax, or email your application along with all required documentation to:

### St. Luke's Health System

Financial Care  
P.O. Box 2578  
Boise, ID 83701

**Fax:** (208) 706-7619 (Attention: Financial Care)

**Email:** [pfsfincare@slhs.org](mailto:pfsfincare@slhs.org) (Subject: Financial Care)

## Need Help?

If you would like help completing this application or have questions about required documents, please contact a Patient Financial Advocate at (208) 706-6229 or email [pfsfincare@slhs.org](mailto:pfsfincare@slhs.org).



**National Health Service Corps  
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**Applicant/Co-Applicant**

'Applicant' (primary contact)

'Co-Applicant' (spouse, significant other or domestic partner etc.)

<b>Applicant Name:</b>		<b>Co-Applicant Name:</b>	
<b>Social Security Number:</b>	<b>Date of Birth:</b>	<b>Social Security Number:</b>	<b>Date of Birth:</b>
<b>Phone:</b>	<b>Email:</b>	<b>Phone:</b>	<b>Email:</b>
<b>Address:</b>			

**List of Household Members**

Name	Date of Birth	Relationship to Applicant

**Employment/ Income**

Please provide Gross Monthly Income details (before deductions) for all household members over the age of 18

Applicant		Co-Applicant	
<b>Employer or Business Name:</b> Hire Date:		<b>Employer or Business Name:</b> Hire Date:	
<b>Employment/Self Employment:</b> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Seasonal <input type="checkbox"/>	\$	<b>Employment/Self Employment:</b> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Seasonal <input type="checkbox"/>	\$
<b>Child/Adult Support/Alimony:</b>	\$	<b>Child/Adult Support/Alimony:</b>	\$
<b>Social Security/Disability:</b>	\$	<b>Social Security/Disability:</b>	\$
<b>Public Assistance/ Food Stamps/ Unemployment etc.:</b>	\$	<b>Public Assistance/ Food Stamps/ Unemployment etc.:</b>	\$
<b>Retirement/Pension/Social Security Retirement:</b>	\$	<b>Retirement/Pension/Social Security Retirement:</b>	\$
<b>Rental Property Income:</b>	\$	<b>Rental Property Income:</b>	\$
<b>Income from other sources Describe:</b>	\$	<b>Income from other sources Describe:</b>	\$

**Disclosure and Signature**

By signing and submitting this application to St. Luke's, I certify that all the information I provided is true and complete to the best of my knowledge. I hereby authorize St. Luke's Health System to investigate any statements or data given by me or any person pertaining to my financial responsibility. If I knowingly and with intent to defraud or deceive, or provide false information, I will be denied financial assistance for current and future services and will be liable for all charges. We reserve the right to verify all information provided on this application by any means available to us.

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Co-Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_