St. Luke's Health System

National Health Service Corps Financial Care Application

Medical bills may be difficult to pay. Patients who are unable to pay for all or part of their health care services may apply for financial care by completing and returning this completed and signed form. Patients and families who meet certain income requirements may qualify for discounted care based on their family size and income, even if you have health insurance. To view our financial care policy and discount guidelines visit St. Luke's online: https://www.stlukesonline.org

Patients submitting a Financial Care Application for services received at St. Luke's must submit the below items to determine if you meet eligibility requirements for financial assistance.

Please include copies of the documents requested below:

- Copies of pay stubs from the last 30 days for each household member
- Current year Federal Income Tax return and W-2(s), or just W-2(s) if current year taxes have not been filed with copy of Federal Tax Extension, Form 4868
- Documentation of all sources of income from all household members, 18 years old or older (i.e., proof of rental income, worker's compensation, disability, pension/dividends, trust, unemployment, etc.)
- Most recent bank statement(s), to include all transactions (deposits & withdrawals) for all bank accounts (optional for those at or below 200% of Federal Poverty Guidelines.)
- If self-employed, provide the Schedule C, 3 months of profit and loss (PnL) statements, and 3 months of bank statements (personal and business)
- If receiving public or other assistance, provide documentation (i.e., food stamp verification, cash assistance verification, etc.)
- Social Security determination letter
- If you do not have a source of income, provide a written statement explaining how monthly expenses are being met

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

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 Subject: Financial Care

When St. Luke's receives a complete application and required documents, all self-pay balances will be placed on hold. Once the review has been completed a determination letter will be mailed. If your application is incomplete, your account will be placed on a 30-day hold awaiting the return of any additional required document(s).

If you would like to discuss your financial situation, please contact a Customer Care Representative. Call (208) 706-5999 or email pfsfincare@slhs.org.

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Applicant/Co-Applicant

'Applicant' (primary contact)		'Co-Applicant' (spouse, significant other or domestic partner etc.)	
Applicant Name:		**Co-Applicant Name:**	
Date of Birth:		**Date of Birth:**	
Phone:	**Email:**	**Phone:**	**Email:**
Address:			

List of Household Members

'Household Members' includes people who reside in your home and who you financially support.

Name	Date of Birth	Relationship

Employment/ Income

Please provide Gross Monthly Income details (prior to deductions) for Applicant/Co-Applicant and include all supporting documentation. If employment is seasonal, enter your Annual Gross Income (AGI)

Applicant		Co-Applicant	
Employment/Self Employment: **Annual ☐ Monthly ☐ Seasonal ☐**	**$**	**Employment/Self Employment:** **Annual ☐ Monthly ☐ Seasonal ☐**	**$**
Child/Adult Support/Alimony:	**$**	**Child/Adult Support/Alimony:**	**$**
Social Security/Disability:	**$**	**Social Security/Disability:**	**$**
Pension:	**$**	**Pension:**	**$**
Public Assistance/ Food Stamps/ Unemployment etc.:	**$**	**Public Assistance/ Food Stamps/ Unemployment etc.:**	**$**
Income from other sources Describe:	**$**	**Income from other sources Describe:**	**$**

Disclaimer 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:** _____