



P.O. Box 2578
Boise, Idaho 83701

The completed application is used to determine your eligibility for our financial assistance programs or to establish a mutually agreeable payment arrangement.

When submitting your application, please include the following **(Do not send originals)**:

- A copy of last year's Federal Tax Return
- A copy of your most recent pay stub
- A copy of your bank statement from this month
- A copy of your W-2's
- If receiving public or other assistance, please provide documentation

Please return requested information in the enclosed envelope within 2 weeks. St. Luke's will send written notification of the determination within 3 weeks of receiving your paperwork. If you would like to discuss your financial situation in person please call 208-706-2333 to schedule an appointment.

If this information is not returned your account will continue to flow through St. Luke's collection procedures until we arrive at a mutually agreeable determination.

A Message about our Privacy Policy

Legislation requires us to inform you on how we obtain and protect nonpublic personal information about you which we acquire from the following sources:

- Information we receive from you on applications or other forms you complete;*
- Information about your transaction with us, our affiliates, or others, such as your payment history or your account balances;*
- Information we received from a consumer reporting agency; and*
- Information we obtain from others in the process of verifying information you provide us.*

We do not disclose your nonpublic personal information to anyone, except as permitted by law.



190 East Bannock Street
Boise, ID 83712
Attn: Financial Services

Boise Meridian Wood River

FINANCIAL ASSISTANCE APPLICATION

Patient Name:		Date of Birth:	
Responsible Party Name:		Marital Status:	
Address:		City:	
		State:	Zip:
Social Security#:	Date of Birth:	Phone:	
Employer:	Phone:	Hire Date:	
Address:		City:	
Previous Employer:		State:	Zip:
Spouse Name:	Social Security#:	Date of Birth:	
Employer:	Phone:	Hire Date:	
Dependants: (List Members in Household-for additional members attach a separate sheet)			
Name	Age	Relationship	

Have you applied for Medicaid and been denied?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Have you asked for assistance from your family?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
How much are you able to pay each month?	\$ _____		

MONTHLY INCOME INFORMATION:		
The following income sources are required for verification:		
<small>W-2 forms, income tax statements, check stubs or check statements. If self-employed, a financial statement is required.</small>		
SOURCE OF INCOME	RESPONSIBLE PARTY	SPOUSE
Wages (before deductions)	\$	\$
Child Support/Adult Support/Alimony	\$	\$
Disability/Worker's Compensation	\$	\$
Pension	\$	\$
Social Security Income	\$	\$
Dividends/Interest/Income	\$	\$
Rental Income	\$	\$
Estate/Trust Income	\$	\$
Public Assistance	\$	\$

Food Stamps	\$	\$
Other	\$	\$
Less FICA/State/Federal Taxes:	\$	\$
Less any other Deductions:	\$	\$
MONTHLY INCOME TOTAL:	\$	\$

ASSETS / RESOURCES	RESPONSIBLE PARTY	SPOUSE
Checking Account	\$	\$
Savings Account	\$	\$
Stocks / Bonds / CDs / IRA / 401K / Retirement	\$	\$
ASSETS / RESOURCES TOTAL:	\$	\$

Have you ever filed bankruptcy? Yes No If yes, enter Year: _____ and Chapter: _____
 Payment amount (if applicable): \$ _____

ALL REAL PROPERTY / VEHICLES	BALANCE	MONTHLY PAYMENT
Residence: <input type="checkbox"/> Own <input type="checkbox"/> Rent	\$	\$
Other property (list)	\$	\$
Vehicle #1: Model: _____ Year: _____	\$	\$
Vehicle #2: Model: _____ Year: _____	\$	\$
Recreational Vehicle: Model: _____ Year: _____	\$	\$
Other Vehicle: Model: _____ Year: _____	\$	\$
All Real Property / Vehicles Subtotal:	\$	\$

CREDITORS	BALANCE	MONTHLY PAYMENT
Credit Card	\$	\$
Credit Card	\$	\$
Credit Card	\$	\$
Credit Card	\$	\$
Credit Card	\$	\$
Student Loan	\$	\$
Other Loan / Creditor	\$	\$
Other Loan / Creditor	\$	\$
Creditors Subtotal:	\$	\$

OTHER MONTHLY EXPENSES	BALANCE	MONTHLY PAYMENT
Groceries	\$	\$
Auto Insurance	\$	\$
Gasoline / Auto Maintenance	\$	\$
Health Insurance (if not deducted from payroll)	\$	\$
Utilities: Heating Fuel	\$	\$
Home Phone	\$	\$
Cell Phone	\$	\$

Water / Sewer / Trash	\$	\$
Electricity	\$	\$
Cable TV	\$	\$
Internet	\$	\$
Life Insurance	\$	\$
Renter / Homeowner Insurance (if not included in mortgage)	\$	\$
Child Support and/or Day Care	\$	\$
Clothing	\$	\$
Charitable Contributions	\$	\$
Other: _____	\$	\$
Other Monthly Expense Subtotal:	\$	\$

MEDICAL EXPENSES	BALANCE	MONTHLY PAYMENT
Hospital (name):	\$	\$
Hospital (name):	\$	\$
Hospital (name):	\$	\$
Physician (name):	\$	\$
Physician (name):	\$	\$
Physician (name):	\$	\$
Prescriptions:	\$	\$
Medical Expenses Subtotal:	\$	\$

MONTHLY FINANCIAL SUMMARY	BALANCE	MONTHLY PAYMENT
Monthly Income Totals (include spouse) from page 3:	\$	
Monthly payments on all real property / vehicles from page 3:▶	\$
Monthly payments to creditors from page 3:▶	\$
Other monthly expenses from page 4:▶	\$
Monthly medical expenses from page 4:▶	\$
TOTAL MONTHLY EXPENSES:▶	\$
NET DIFFERENCE:	\$	

If expenses are more than the income listed, please describe how expenses are met each month:

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I hereby state that the information I have provided is true and complete. I authorize the hospital to verify this information, including requesting a Credit Bureau Report when necessary. I understand that if any of this information is determined to be deceptive or false, I may be denied special financial consideration and I will be liable for any and all charges incurred for services rendered.

_____ Responsible Party

_____ Date

For PFS Use Only: Guarantor Number(s):

Patient Name: