# 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 a National Health Service Corps (NHSC) location must submit the below items to determine if you meet eligibility requirements for financial assistance. To view a list of qualifying NHSC locations visit: www.stlukesonline.org/NHSCLocations.

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 family members 18 years old or older (i.e., proof of rental income, worker's compensation income statement, pension/dividends income statement, trust income statement, unemployment benefit statement, etc.)
- Most recent bank statements for all bank accounts
- If self-employed, provide the Schedule C, 3 months of profit and loss (PnL) statements, and 3 months of bank statements
- If receiving public or other assistance, please provide documentation (i.e., food stamp verification, cash assistance verification, etc.)
- Social Security determination letter
- If you do not have a source of income, please provide a letter explaining your situation

**Services that are eligible for external financial assistance options (e.g., Affordable Care Act, State or County assistance) may not be eligible for internal financial care.**

Please mail or fax 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

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) 706-2333, toll free at 800-342-3432, or email pfscustomerservice@slhs.org

# St. Luke's Health System

National Health Service Corps Financial Care Application

## Applicant Information

| | | | |
|---|---|---|---|
| **Full Name:** | | | |
| **Address:** | | | |
| | | | |
| **Phone:** | | **Email:** | |
| **Date of Birth:** | | **Social Security Number: (Optional)** | |

## Co-Applicant Information

"Co-Applicant" is defined as anyone living in the household. (i.e., Spouse, Significant Other, Domestic Partner etc.)

| | | | |
|---|---|---|---|
| **Full Name:** | | **Relationship to Applicant:** | |
| **Phone:** | | **Email:** | |
| **Date of Birth:** | | **Social Security Number: (Optional)** | |

## List of Dependents in Household

"Dependents" includes people related by birth, or adoption who live in your household and who you financially support.

| Dependents Name | Date of Birth | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Employment

| Applicant | Co-Applicant |
|---|---|
| **Employer:** | **Employer:** |
| **Hire Date:** | **Hire Date:** |
| **If Self-Employed: Occupation?** | **If Self-Employed: Occupation?** |

# St. Luke's Health System

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| | | | |
|---|---|---|---|
| **Applicant Name:** | | **Date of Birth:** | |
| **Co-Applicant Name:** | | **Date of Birth:** | |

## Income

Household income less than 200% of the Federal Poverty Guidelines (FPL) will qualify for 100% financial care to meet National Health Service Corps guidelines. If your household income is above 200% FPL, please complete our standard Financial Care Application at https://www.stlukesonline.org/. If employment is seasonal enter your Annual Gross Income (AGI).

| **Applicant** | | **Co-Applicant** | |
|---|---|---|---|
| **Wages (before deductions): Annual: ☐Monthly: ☐** | **$** | **Wages (before deductions): Annual: ☐ Monthly: ☐** | **$** |
| **Child Support/ Adult support/ Alimony:** | **$** | **Child Support/ Adult Support/ Alimony:** | **$** |
| **Disability/ Workers Compensation:** | **$** | **Disability/ Workers Compensation:** | **$** |
| **Pension:** | **$** | **Pension:** | **$** |
| **Social Security Income:** | **$** | **Social Security Income:** | **$** |
| **Dividends/ Interest/ Trust/ Estate/ Rental Income:** | **$** | **Dividends/ Interest/ Trust/ Estate/ Rental Income:** | **$** |
| **Public Assistance/ Food Stamps/ Unemployment etc.:** | **$** | **Public Assistance/ Food Stamps/ Unemployment etc.:** | **$** |
| **Income from Other Sources Describe:** | **$** | **Income from Other Sources Describe:** | **$** |
| **Total:** | **$** | **Total:** | **$** |

## 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 any and all charges. We reserve the right to verify all information provided on this application by any means available to us.

I authorize St. Luke's Health System to verify the information I have provided.

**Applicant Signature:** _____ Date: _____

**Co-Applicant Signature**: _____ Date: _____