Dear Patient and Family:

In keeping with its mission and core values, we are committed to providing health care for patients, regardless of their ability to pay.

Our Financial Care:

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 free 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

You must provide information on your family's income. Income verification is required to determine financial care**. All family members 18 years old or older who are applying for financial care must disclose every identified source of income.**

Required documents for proof of income include the following:

- Most recent year's income tax return, including schedules, if applicable
- Most recent pay stub(s)
- Most recent bank statement(s), to include all transactions (deposits & withdrawals) for all bank accounts.
- If **self-employed**, provide the 1099 Schedule C and 3 months of profit and loss statements
- Documentation of any other source of income (proof of rental income, worker's compensation income statement, pension/dividends income statement, trust income statement, unemployment benefit statement, etc.)
- Social Security award letter, if applicable
- If receiving public or other assistance, please provide documentation (food stamp verification, cash assistance verification, etc.)

Alternative documents to those listed above:

- Written and signed statements from employers if unable to provide recent paystub
- Most recent "W-2" withholding statement if unable to provide recent year's income tax return

If you have no proof of income or no income, please attach a letter of explanation.

Please send the application along with all required supporting documentation to:

Mail: St. Luke's Health System
Attn: Financial Care
P.O. Box 2578
Boise, ID 83701

Fax: Attn: Financial Care
(208) 706-7619

If your application is incomplete, your information will be returned to you. Your account will be placed on a 30 day hold awaiting the return of the completed application and additional required document(s). Once a completed financial care application has been received St. Luke's will send written notification of the determination.

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

Financial Care Application

Patient Name(s):		Date of Birth:	
Responsible Party Name:		Marital Status:	
Address:		City:	
		State:	Zip:
Social Security#:	Date of Birth:	Phone:	

Employer:		Phone:	Hire Date:
Address:		City:	
Self Employed: Yes or No	Occupation:	State:	Zip:

Spouse/Significant Other/Partner Name:	Social Security#:	Date of Birth:
Employer or Self Employed:	Phone:	Hire Date:

LIST MEMBERS IN HOUSEHOLD *(use the back of this form for additional dependents names, DOB, and relationship)* →

Dependents Name(s)	Date of Birth	Relationship

SOURCE OF INCOME	RESPONSIBLE PARTY	SPOUSE/SIGNIFICANT OTHER/ PARTNER
Wages (before deductions)	$	$
Child Support/Adult Support/Alimony	$	$
Disability/Worker's Compensation	$	$
Pension	$	$
Social Security Income	$	$
Dividends/interest/ Trust/Estate/ Rental Income	$	$
Public Assistance/Food Stamps/Unemployment etc.	$	$
Income from other sources (please specify)	$	$.
Total	$	$

HOUSEHOLD ASSETS	VALUE	AMOUNT OWED
Checking Account(s) Balance	$	$
Savings Account(s) Balance	$	$
Stocks/Bonds/IRA/401 K	$	$
Home(s)	$	$
Other Assets	$	$
Total	$	$

How much are you able to pay St. Luke's Health System monthly?		

If expenses are more than the income listed, please use the back of this form to describe how expenses are met each month. →

By signing and submitting this application to St. Luke's, I certify that all of the information I provided is true and complete to the best of my knowledge. If I knowingly and with intent to defraud or deceive, provide false information, I will be denied financial assistance for current and future services, and will be liable for any and all charges.

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

Responsible Party Signature _____ Date _____

For PFS Use Only: Epic Guarantor Number(s):