St. Luke's Hospital

Financial Assistance Application

Directions for completing application:

Please complete all of the fields on this application **and sign** the application where indicated. Please provide all types of gross and household income as indicated below. Proof of your income should include the following; If you have any questions please contact us at: 800-304-9668.

Please note all information provided is confidential and is only used for the purpose of determining your discount.

	401K/Retirement/CD/etc. Statements		Submit a letter describing your financial situation
	Pay stubs for 90 Days for all income reported		Social Security Benefits (if applicable)
	Unemployment statements for 90 days		Checking and savings bank statement
	Property tax statement		Mortgage balance statement
	Current Federal Tax returns and supporting Schedules To request a copy of your taxes, please call 1-800-829-1040		If you did not file taxes, please explain in a letter

If your family income after January 26th, 2017 is within the income ranges below, you may be eligible to receive free care for necessary medical services even if you have insurance.

Family Size	100% FPG
1	$12,060
2	$16,240
3	$20,420
4	$24,600
5	$28,780
For each additional person add $4,180	

If you do not have insurance and your family income after January 26, 2017 is within the ranges below, you may be eligible for discounted care.

Family Size	400% FPG
1	$48,240
2	$64,960
3	$81,680
4	$98,400
5	$115,120
For each additional person add:	$16,640

PLEASE PRINT- BE SURE TO PROVIDE ALL REQUESTED INFORMATION

Today's Date: _____ Visit/Account #: _____

Patient Name: _____ Patients DOB: _____/_____/_____

Last 4 Digits of Patients Social Security #: _____ Patients Marital Status: S M W D Gender: M F

Patients Address:

_____

City: _____ State:_____ Zip:_____ County: _____

Citizen of the USA: _____ Home Phone #: _____ Cell Phone #: _____

Please provide your email address if you would like to receive communication regarding this application via email.

_____

Were you an Ohio resident at the time of your service? Yes No

Please provide the following information for all the people in your immediate family that live in your home. For the purposes of this application, "family" is identified as the patient, patient's spouse, and natural or adopted children under the age of 18 who live in the patient's home, please include parent's income.

If there is no income, please explain how patient is supporting self: _____
_____

Name	Age	Relationship to patient	Gross income 3 months prior to service	Gross income 12 Moths prior to service	Current gross Monthly income	Type of Income
		TOTALS:				

Patient/Guarantor employer for the last 12 months:
Name of employer: _____ Date hired: _____ Date ended: _____
Name of employer: _____ Date hired: _____ Date ended: _____

Spouse's employer:
Name of employer: _____ Date hired: _____ Date ended: _____
Name of employer: _____ Date hired: _____ Date ended: _____

Have you applied for Medicaid: Yes No If yes, what were the results? _____
If no, you were denied by Medicaid why? _____
Have you applied for Social Security disability assistance? Yes No
If yes what were the results? Approved Denied If approved effective date: _____
Do you have health insurance other than Medicaid? Yes No

Assets:

Checking Balance:	
Stocks:	
Bonds:	
IRA:	
Savings Balance:	
CD:	
401K:	
Other assets:	

Housing:	
Car:	
Food:	
Electric/Gas:	
Medical:	
Other:	

Do you have auto insurance if service is auto related? Yes No
If yes:
Name of insurance company:
_____
Policy #: _____
Address of insurance Company:
_____
Phone #:
_____

By signing below, I state that information on this application is true to the best of my knowledge.

_____
Signature of patient/guarantor Date/Time

_____
Signature of Spouse Date/Time

_____
Signature of Staff Member (if applicable) Date/Time