



St. Luke's Hospital

Financial Assistance Application

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

PLEASE PRINT- BE SURE TO PROVIDE ALL REQUESTED INFORMATION

Patient Information: Print your full name and address at the time you received medical services and other information noted in this section.

Date of Hospital Service: _____ **Account #:** _____

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

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

Patient Address: _____

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

If your family income after January 11th, 2019 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	200% FPG
1	\$24,980
2	\$33,820
3	\$42,660
4	\$51,500
5	\$60,340
For each additional person add	\$8,840

If you do not have insurance and your family income after January 11, 2019 is within the ranges below, you may be eligible for discounted care.

Family Size	400% FPG
1	\$49,960
2	\$67,640
3	\$85,320
4	\$103,000
5	\$120,680
For each additional person add	\$17,680

The following Questions Must be Completed for Financial Assistance Consideration

- 1) Were you an Ohio resident at the time of your hospital service? Yes ___ No ___
- 2) Were you an Active Medicaid recipient at the time of service? Yes ___ No ___
- 3) Have you applied for Medicaid or any other county assistance? Yes ___ No ___
 - a. If yes, what date did you apply _____
 - b. If yes, what state did you apply _____
- 4) Did you have health insurance at the time of your hospital service? Yes ___ No ___
 - a. If yes, Name/Policy of insurance _____
- 5) Please indicate if your Hospital service was related to Auto Accident Yes ___ No ___

Proof of your income is required to complete and approve your application. Type of proof include wage verification including pay stubs, 1 year prior to the date of service you are requesting assistance for, unemployment information, Social Security benefits, Self-employment records, disability or worker's compensation, alimony, child support pensions, income tax returns, etc. Please include copies of these document along with the application and Mail to: **Financial Assistance Department 2701 Highpoint Oaks Dr, Suite 124 Lewisville, TX 75067.** If reporting zero income, please explain how patient is supporting self:

Proof of Income: Please provide the following information for all the people in your immediate family that live in your home. For the purpose 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 income information for each adult over age of 18.

Name	Age	Relationship to patient	Gross Income 3 months prior to service	Gross income 12 months prior to service	Monthly Income	Source of income

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 Staff Member Date/Time