#111 attachment Appendix C – Application

FINANCIAL ASSISTANCE APPLICATION

Medical Record _____ **Telephone _____**

Patient _____ **Employer _____**

Street _____

City, State, Zip _____

Please list total household income.

	Last 12 Months	Last 3 Months
Gross Income		
Other Family Income		
Total Family Income		
Assets-Savings/ IRA/ CD		
Real estate/ Money Market/ Stocks		

Dependents: (Total of people living in household)

	Name	Age	Relationship
1			
2			
3			
4			
5			

I certify that the above information is complete and accurate to the best of my knowledge. Further, I will cooperate with St. Luke's if deemed necessary to apply for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge.

I understand that this application is made so the hospital can determine my eligibility for uncompensated service under the Financial Assistance Program, based on the established criteria on file in the hospital. If any information I have given proves to be incomplete, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

I authorize my bank, loan institution, insurance company, employer, or any creditor whatsoever of the undersigned to release any information requested by St Luke's Hospital pertaining to any and all financial matter involving or related to the undersigned.

_____ _____

Date **Applicant's Signature**

I understand any physician charges related to my services at St. Luke's Hospital are not covered by this program.

01/2024