

#### APPLICATION FOR FINANCIAL ASSISTANCE

To be considered for Financial Assistance, please complete the information below. In addition, a complete copy of the most recent Federal Tax return and proof of income is required for the applicant and all members of the household as indicated in Section 4 of this form. If the applicant or a family member listed in Section 4 is not employed, proof of non-filing is required and can be obtained by calling the IRS at 1-800-829-1040 and requesting Form 4506-T. Incomplete or inaccurate applications may result in a delay or a denial of financial assistance.

The information on this form will be kept confidential and will allow us to do an initial assessment of our qualification for our Financial Assistance Program. We will notify you in writing within14 days of the receipt of your information with a determination of your eligibility or if additional information is needed. If financial assistance is granted, please be advised that we may share information with you other healthcare providers regarding total charges and the percentage of discount that has been awarded.

SECTION 1: APPLICANT INFORMATION				
PATIENT NAME				
DOB				
CURRENT STREET ADDRESS				
CITY/STATE/ZIP				
TELEPHONE #				
SOCIAL SECURITY NUMBER/ITIN				

### **SECTION 2: MEMBERS OF THE HOUSEHOLD**

Please complete the following information for yourself as well as every member in your household 18 years or older. This includes members currently living in your residence and/or listed as a dependent on your Federal Tax Return. Income is also required for members in the household who are unmarried, household partners, and their dependents.

Name	Date of Birth	Relationship	Currently Employed (Y or N)	Employed in the last 6 months (Y or N)	Current and past employer name (for past 6 months)

### APPLICATION FORM cont'd

SEC	CTION 3: BANKING, NON	-RETIREMENT INVESTMENTS, AND OTHER ASSETS			
	Does the applicant have a personal checking account? Y or N				
CHECKING ACCOUNT	Bank Name				
	Cumulative Balance				
	Does the applicant have a personal savings account? Y or N				
SAVINGS ACCOUNT	Bank Name				
	Cumulative Balance				
	Do you own real property (other than primary residence)? Y or N				
OTHER ASSETS	If Yes, which County				
	and State?				
	Do you have non-retirement investments? Y or N				
NON-RETIREMENT	If Yes, what is the				
INVESTMENTS	name of the fund				
(e.g. non-IRAs, 401K)	and current balance?				
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OTHER ASSETS	If Yes, which County				
	and State?				
	Do you have non-retirement investments? Y or N				
NON-RETIREMENT	If Yes, what is the				
INVESTMENTS	name of the fund				
(e.g. non-IRAs, 401K)	and current balance?				

## SECTION 4: GROSS ANNUAL INCOME-PAST 12 MONTHS FOR EACH MEMBER OF HOUSEHOLD

Please complete the following information for all members of the household aged 18 or older as listed in Section 2 above. Proof of income includes but is not limited to wages, tips, pension, IRA or annuities, SSI, child support, alimony, food stamps, cash gifts, grant income, or any other form of income earned. If unemployed, please provide proof from the unemployment office stating whether or not benefits have been received.

Household Member	Source of Income	Amount Received	Frequency of Payment	Form of Proof Attached

### APPLICATION FORM cont'd

# **SECTION 5: APPLICANT CERTIFICATION**

My signature below indicates that the information I provided on this form is complete and accurate. I understand that any information provided on this form, which is found to be false, misleading, or inaccurate may result in a denial of my eligibility for financial assistance with St. Luke's Hospital now and in the future. I authorize St. Luke's Hospital to make necessary inquiries to verify information provided on this application and to release information to any Business Associates or governmental agencies that may require it. I understand that completing this application is not a guarantee of my eligibility.

Applicant's Name and Signature	Date