St. Luke's HOSPITAL

232 S. Woods Mill Road
Chesterfield, MO 63017

To be considered for Financial Assistance, **please complete the information below and return it along with a SIGNED copy of your current tax return and two of your most recent paycheck stubs.**

This information will be kept confidential and will allow us to do an initial assessment of your qualifications for our Financial Assistance Program. We will notify you in writing within 14 days of the receipt of your information with a determination of our review or if additional information is needed. If financial assistance is granted please be advised that we may share information with your other healthcare providers regarding total charges and the percentage of discount that has been awarded.

If you have questions, please call our Customer Service Department, at 314-576-8100 or toll free at 1-888-924-9200, Monday–Friday, 8:30 A.M.– 5:00 P.M.

Very truly yours,

Financial Assistance Committee

❒ **A complete SIGNED copy of your FEDERAL TAX RETURN from the previous year including all schedules and forms.** *(If married, a tax return for both patient and spouse is required. If you do not file taxes and are claimed on someone else's tax return, a complete copy of their return is required.)* ***** If you do not file Federal taxes, proof of non-filing needs to be obtained by calling the IRS at 1-800-829-1040 and requesting Form 4506-T.**

❒ **Proof of income.** Include copies of at least 2 paycheck stubs. Include proof of amounts paid out from pension, IRA or annuities from the previous year. *(Must include proof of income for parents: if claimed on parent's tax return, if living in parent's home or if covered under a parent's insurance plan)*

❒ **If unemployed, proof from the unemployment office stating whether or not benefits have been received.**

❒ **Proof of benefits received from Social Security, Disability, Alimony, Welfare, Child Support, Food Stamps, etc…**

❒ **If there is a change in your marital status, a copy of your divorce decree or proof of legal separation is required.**

Patient Name: _____ Patient Account Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Work/Cell Phone number: _____

Patient/Parent #1 Employer: _____ Monthly gross income: _____

Spouse/Parent # 2 Employer: _____ Monthly gross income: _____

Monthly mortgage/Rent: _____ # of dependent(s) claimed on tax return: _____

If you have no income, how are your housing, food and transportation needs being met?

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