P.O. Box 409
Twin Falls, Idaho 83303

The completed application is used to determine your eligibility for our financial assistance programs or to establish a mutually agreeable payment arrangement.

When submitting your application, please include the following **(Do not send originals)**:

- A copy of last year's Federal Tax Return
- A copy of your most recent pay stub
- A copy of your bank statement from this month
- A copy of your W-2's
- If receiving public or other assistance, please provide documentation

Please return requested information within 2 weeks. St. Luke's will send written notification of the determination within 3 weeks of receiving your paperwork. If you would like to discuss your financial situation in person please call 208-732-3000 to schedule an appointment.

If this information is not returned your account will continue to flow through St. Luke's collection procedures until we arrive at a mutually agreeable determination.

A Message about our Privacy Policy

Legislation requires us to inform you on how we obtain and protect nonpublic personal information about you which we acquire from the following sources:

- *Information we receive from you on applications or other forms you complete;*
- *Information about your transaction with us, our affiliates, or others, such as your payment history or your account balances;*
- *Information we received from a consumer reporting agency; and*
- *Information we obtain from others in the process of verifying information you provide us.*

We do not disclose your nonpublic personal information to anyone, except as permitted by law.

St Luke's

❑ Treasure Valley ❑ Wood River ❑ Magic Valley

P.O. Box 409
Twin Falls, Idaho 83303
Attn: Financial Services

FINANCIAL ASSISTANCE APPLICATION

Patient Name:		Date of Birth:	
Responsible Party Name:		Marital Status:	
Address:		City:	
		State:	Zip:
Social Security#:	Date of Birth:	Phone:	
Employer:	Phone:		Hire Date:
Address:		City:	
Previous Employer:		State:	Zip:
Spouse Name:	Social Security#:		Date of Birth:
Employer:	Phone:		Hire Date:

Dependants: (List Members in Household-for additional members attach a separate sheet)

Name	Age	Relationship

Have you applied for Medicaid and been denied? Yes ☐ No ☐
Have you asked for assistance from your family? Yes ☐ No ☐
How much are you able to pay each month? $______________________

MONTHLY INCOME INFORMATION:
The following income sources are required for verification:
W-2 forms, income tax statements, check stubs or check statements. If self-employed, a financial statement is required.

SOURCE OF INCOME	RESPONSIBLE PARTY	SPOUSE
Wages (before deductions)	$	$
Child Support/Adult Support/Alimony	$	$
Disability/Worker's Compensation	$	$
Pension	$	$
Social Security Income	$	$
Dividends/interest/Income	$	$
Rental Income	$	$
Estate/Trust Income	$	$
Public Assistance	$	$

Food Stamps	$	$
Other	$	$
Less FICA/State/Federal Taxes:	$	$
Less any other Deductions:	$	$
MONTHLY INCOME TOTAL:	**$**	**$**

ASSETS / RESOURCES	RESPONSIBLE PARTY	SPOUSE
Checking Account	$	$
Savings Account	$	$
Stocks / Bonds / CDs / IRA / 401K / Retirement	$	$
ASSETS / RESOURCES TOTAL:	**$**	**$**

Have you ever filed bankruptcy? ❑ Yes ❑ No *If yes, enter Year:________ and Chapter: ___________________*
Payment amount (if applicable): $______________________________

ALL REAL PROPERTY / VEHICLES	BALANCE	MONTHLY PAYMENT
Residence: ❑ Own ❑ Rent	$	$
Other property (list)	$	$
Vehicle #1: Model: Year:	$	$
Vehicle #2: Model: Year:	$	$
Recreational Vehicle: Model: Year:	$	$
Other Vehicle: Model: Year:	$	$
All Real Property / Vehicles Subtotal:	**$**	**$**

CREDITORS	BALANCE	MONTHLY PAYMENT
Credit Card	$	$
Credit Card	$	$
Credit Card	$	$
Credit Card	$	$
Credit Card	$	$
Student Loan	$	$
Other Loan / Creditor	$	$
Other Loan / Creditor	$	$
Creditors Subtotal:	**$**	**$**

OTHER MONTHLY EXPENSES	BALANCE	MONTHLY PAYMENT
Groceries	$	$
Auto Insurance	$	$
Gasoline / Auto Maintenance	$	$
Health Insurance (if not deducted from payroll)	$	$
Utilities: Heating Fuel	$	$
Home Phone	$	$
Cell Phone	$	$

Water / Sewer / Trash	$	$
Electricity	$	$
Cable TV	$	$
Internet	$	$
Life Insurance	$	$
Renter / Homeowner Insurance (if not included in mortgage)	$	$
Child Support and/or Day Care	$	$
Clothing	$	$
Charitable Contributions	$	$
Other: ___________________________________	$	$
Other Monthly Expense Subtotal:	**$**	**$**

MEDICAL EXPENSES	BALANCE	MONTHLY PAYMENT
Hospital (name):	$	$
Hospital (name):	$	$
Hospital (name):	$	$
Physician (name):	$	$
Physician (name):	$	$
Physician (name):	$	$
Prescriptions:	$	$
Medical Expenses Subtotal:	**$**	**$**

MONTHLY FINANCIAL SUMMARY	BALANCE	MONTHLY PAYMENT
Monthly Income Totals (include spouse) from page 3:	$	
Monthly payments on all real property / vehicles from page 3:	..........►	$
Monthly payments to creditors from page 3:	..........►	$
Other monthly expenses from page 4:	..........►	$
Monthly medical expenses from page 4:	..........►	$
TOTAL MONTHLY EXPENSES:	..........►	**$**
NET DIFFERENCE:	**$**	

If expenses are more than the income listed, please describe how expenses are met each month:

I hereby state that the information I have provided is true and complete. I authorize the hospital to verify this information, including requesting a Credit Bureau Report when necessary. I understand that if any of this information is determined to be deceptive or false, I may be denied special financial consideration and I will be liable for any and all charges incurred for services rendered.

_______________________________________ Responsible Party

_______________ Date

For PFS Use Only: Guarantor Number(s):

Patient Name: