ST. LUKE'S

# 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 15th, 2020 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 | $25,520 |
| 2 | $34,480 |
| 3 | $43,440 |
| 4 | $52,400 |
| 5 | $61,360 |
| For each additional person add | $8,960 |

**If you do not have insurance** and your family income after January 15, 2020 is within the ranges below, you may be eligible for discounted care.

| Family Size | 400% FPG |
|---|---|
| 1 | $51,040 |
| 2 | $68,960 |
| 3 | $86,880 |
| 4 | $104,800 |
| 5 | $122,720 |
| For each additional person add | $17,920 |

**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