Please complete the attached Financial Care Application. The completed application and supporting documentation is used to determine your eligibility for our financial assistance program or to establish a mutually agreeable payment arrangement.

Supporting documentation is required for all responsible parties in the household, including spouse, if applicable. Please return the completed application and include legible copies of the following documents (do not send originals).

Please indicate on the list below if any of the requested documents are not applicable (for example, if you are not required to file taxes, put a brief explanation beside that line).

- Most recent US Federal Tax Return
- Most recent W-2(s)
- Most recent complete bank statement(s), to include all transactions (deposits & withdrawals) for all bank accounts
- Documentation of any other source of income (proof of rental income, worker's compensation income statement, pension/dividends income statement, trust income statement, unemployment benefit statement, etc.)
- Social Security award letter, if applicable
- Most recent pay stub(s)
- If Self-employed: Please provide three most recent complete bank statements, to include all transactions (deposits/withdrawals), for all accounts; personal and business
- If receiving public or other assistance, please provide documentation (food stamp verification, cash assistance verification, etc.)

Please send the application along with all required supporting documentation to:

Mail: St. Luke's Health System
Attn: Financial Care
P.O. Box 2578
Boise, ID 83702

Fax: Attn: Financial Care
(208) 706-7619

If your application is incomplete, your information will be returned to you. Your account will continue to flow through St. Luke's collection process until we arrive at a mutually agreeable determination.

St. Luke's will send written notification of the determination.

If you would like to discuss your financial situation please contact a Customer Care Representative. Call (208) 706-2333, toll free at 800-342-3432, or email pfscustomerservice@slhs.org

St Luke's

Financial Care Application

Patient Name(s):		Date of Birth:	
Responsible Party Name:		Marital Status:	
Address:		City:	
		State:	Zip:
Social Security#:	Date of Birth:	Phone:	
Employer:	Phone:		Hire Date:
Address:		City:	
Self Employed: Yes or No	Occupation:	State:	Zip:
Spouse/Significant Other/Partner Name:	Social Security#:		Date of Birth:
Employer or Self Employed:	Phone:		Hire Date:

LIST MEMBERS IN HOUSEHOLD *(use the back of this form for additional dependents names, DOB, and relationship)* →		
Dependents Name(s)	Date of Birth	Relationship

SOURCE OF INCOME	RESPONSIBLE PARTY	SPOUSE/SIGNIFICANT OTHER/ PARTNER
Wages (before deductions)	$	$
Child Support/Adult Support/Alimony	$	$
Disability/Worker's Compensation	$	$
Pension	$	$
Social Security Income	$	$
Dividends/interest/Trust/Estate/Rental Income	$	$
Public Assistance/Food Stamps/Unemployment etc.	$	$
Income from other sources (please specify)	$	$.
Total	$	$

ASSETS	RESPONSIBLE PARTY	SPOUSE/SIGNIFICANT OTHER/ PARTNER
Checking Account(s) Balance	$	$
Savings Account(s) Balance	$	$
Stocks/Bonds/IRA/401K	$	$
Home(s)/Car(s)/Boats(s)/Business(s)	$	$
Other Assets	$	$
Total	$	$

How much are you able to pay St. Luke's Health System monthly?		

If expenses are more than the income listed, please use the back of this form to describe how expenses are met each month. →

By signing and submitting this application to St. Luke's, I certify that all of the information I provided is true and complete to the best of my knowledge. If I knowingly and with intent to defraud or deceive, provide false information, I will be denied financial assistance for current and future services, and will be liable for any and all charges.

I authorize St. Luke's Health System to verify the information I have provided.

_____ _____

Responsible Party Signature Date

For PFS Use Only: Epic Guarantor Number(s):