St. Luke Community Healthcare

*The **HEART** of the Mission Valley*

PATIENT FINANCIAL ASSISTANCE APPLICATION

Part 1

St. Luke Community Hospital is committed to providing all of your medical services with sensitivity to your medical and financial needs. Please help us by completing the following questionnaire to determine if you may qualify for reduced fees under our Patient Financial Assistance Program. Please return this form within thirty (30) days.

Name:_____ SSN:_____ DOB:_____

Spouse:_____ SSN:_____ DOB:_____

Street Address:_____ City/State:_____ Zip:_____

Mailing Address:_____ City/State:_____ Zip:_____

Daytime Phone:_____ Message Phone:_____

Employer:_____ Position:_____ Hire Date:_____

Does your employer provide Health Insurance Y or N.
If yes please list Insurance Company:_____

Spouse Employer:_____ Position:_____ Hire Date:_____

Does your spouse's employer provide Health Insurance Y or N.
If yes please list Insurance Company:_____

Number of Dependants:_____ Ages: _____

Are you currently on any Public Assistance Program (WIC, TANF, SNAP, HMK, LIEAP, MCD, etc.)
Yes ___ No__

If you answered Yes, please list which program, or programs, you are participating in. You must provide proof (i.e. copy of letter or card) of which program you are currently on and attach it to Part 1 of the Application.

_____

If you answered NO to the previous question please fill out Part 2 of the application.

Part 1 cont.

For **services already rendered** by St. Luke, list date of services and dollar amounts:

_____ $_____

I hereby request Financial Assistance from St. Luke for me, or my family member named above. I certify that all the information submitted is true, accurate and complete. I also certify that at this time I am unable to pay for the health services in full. I understand that the information, which I submit, may be subject to review by Federal and/or State enforcement agencies and others as required by law. In order that St. Luke may act upon my request, I agree to supply St. Luke, its managers, operators; agents or employees, any additional information as reasonably requested in order to verify my income.

I authorize any financial institution, government agency, or like entity, as well as St. Luke, its respective agents and employees, to release any information necessary to verify the contents of this application, and further release all parties from any and all liability arising out of their reasonable efforts to do the same.

The undersigned hereby authorizes St. Luke to investigate any references listed or statements or other data obtained from me or from any other person pertaining to my credit and financial responsibility and to obtain a consumer credit report for the purpose of evaluation of this Application.

_____ _____
Patient Signature Date

_____ _____ _____
Requestor Signature Relationship to Patient Date
(Requested on behalf of patient)

ACCEPTED **DECLINED**

_____ _____
Authorized Signature Date

_____ _____
Authorized Signature Date