St. Luke's Financial Assistance Program

Date completed, application received _____

This application applies to St. Luke's Hospital and Clinics, Lake View Hospital and Clinic, and St. Luke's Hospice and Home Care Services

Applicant/Responsible Party: _____ _____ _____
Last First MI

Patient Name: _____ _____ _____
(*if different than applicant)* Last First MI

Applicant Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____

Email Address: _____

U.S. Citizen: ☐ Yes ☐ No **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Was Medical Assistance denied? ☐ Yes ☐ No
Is applicant ineligible for Medical Assistance? ☐ Yes ☐ No

If YES to either of the above, state reason(s) why: _____

- ***Attach copy of written Medical Assistance denial letter if received***

Complete information below on each household member (List the applicant first)

Name	Relationship to Applicant	Date of Birth	Type of Health Insurance Company & ID#	Student (Yes/No)	Employed (Yes/No)	Primary care doctor/clinic

INCOME INFORMATION

A. Employment:

Applicant Social Security # _____ **Employer:** _____

Spouse/Household member Social Security # _____ **Employer:** _____

If Self-Employed:

Adjusted Gross Operating Income and Expenses from most recent tax return:

Income: _____ Expenses: _____

B. Income Information

Monthly Income of All Household Members

Income Source per month	Applicant	Spouse or Household Member	Household Member
Employment (Gross amount)			
Interest Income			
Social Security/SSI			
Disability			
Unemployment Compensation			
Worker's Compensation			
Pension(s)			
Child Support			
Alimony			
Military Pay			
Other:			
Other:			

Attach <u>both</u> of the following documentation for all household members:

- ***Copies of your paycheck stubs or a written statement from your employer(s) showing earnings for the past three (3) months including Year to Date gross earnings.***
- ***Copy of last year's tax return for each adult household member including Self Employment return info.***

<u>ASSET INFORMATION</u>

A. Banking Information for all eligible Household Members (Checking & savings; not loans)

- ***Attach copy of the 3 most recent statements showing balance in each account***

1. Checking Accounts:

Bank Name:_____ *Current Balance:* _____

*Bank Name:*_____ *Current Balance*: _____

2. Savings Accounts:

*Bank Name:*_____ *Current Balance*: _____

Bank Name:_____ *Current Balance*: _____

B. **Property**

- ***Attach previous year's property tax bill(s) indicating current market value***

Do you rent or own your home? Rent Own (circle one)

Home Owner: *Fair Market Value* _____

Balance on Mortgage _____

Other Property: *Fair Market Value* _____

Balance on Mortgage _____

C. Vehicles/Recreational

(List all cars, trucks, boats, campers, motorcycles, recreational vehicles, etc)

Type of Vehicle	Model	Year	Estimated Value	Loan Balance

D. Retirement and other Investments (Stocks, Bonds, Annuities, mutual funds, IRA, 401k etc.)

- ***Attach copy of the most recent statement(s) showing value of each investment listed***

Type of Investment	Amount/Cash Surrender Value	Primary Account Holder

I understand that the information provided is subject to verification. I certify that the information on this application is true and correct to the best of my knowledge. I agree to notify this organization promptly of any changes to the information in this document.

Applicant's Signature:_____Date:_____

*Note additional instructions on the reverse side. Rev 1/2020

ADDITIONAL INFORMATION

- Please provide any additional information, financial or other, that would help us evaluate your request for assistance. This can be included as an attachment.

- Attach additional information if there is insufficient space on the application in any category.

- Provide the following documentation:

    - Copy of written denial letter from Medical Assistance if applicable
    - Copies of your 3 most current paycheck stubs including year to date gross earnings or a written statement from your employer showing earnings and YTD gross.
    - Copy of last year's tax return. If self-employed, include income and expenses to current date
    - Copies of the most recent 3 statement(s) showing balance in each bank account(s)
    - Copies of the most recent statement(s) showing value of each investment listed
    - Copies of previous year's property tax bill(s) indicating current market value
    - Copy of your Social Security Award letter for the previous and current year

Mail to:
St. Luke's Hospital
Financial Counselor Office, 1 West
915 E. 1st Street
Duluth, MN 55805
Phone: 218.249.5340, 1.800.303.5340 Fax: 218.249.5602
Email: FinancialCounselor@slhduluth.com

Lake View Hospital
Business Office
325 11th Avenue
Two Harbors, MN 55616
Phone: 218.834.7316, 1.800.834.8890 Fax: 218.834.7388
Email: LakeviewFinancialCounselor@slhduluth.com

St. Luke's Clinics
Central Billing Office
4702 Grand Avenue
Duluth, MN 55807
Phone: 218.249.6870, 1.1800.689.2085 Fax: 218.249.6879
Email: CBOCS@slhduluth.com

St. Luke's Hospice & Home Health Services
220 N. 6th Avenue E.
Duluth, MN 55805
Home Health Phone: 218.249.6111 Fax: 218.249.6166
Hospice Phone: 218.249.6100 Fax: 218.249.6166