



### 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, St. Luke's Pavilion Surgery Center, 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**

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

*Attach both 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.*

**ASSET INFORMATION**

**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.

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## **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

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, 1.800.689.2085

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

#### **St. Luke's Pavilion Surgery Center**

Financial Counselor Office

915 East 1<sup>st</sup> St

Duluth, MN 55805

Phone: (218) 249-5340

Fax: (218)249-5602

Email: FinancialCounselor@slhduluth.com