St. Luke's FINANCIAL ASSISTANCE PROGRAM

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: _____

If not self-employed last year, provide income for the last 3 months: _____

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			
Public Assistance			
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 twelve (12) months***
- ***Copy of last year's tax return for each adult household member***

ASSET INFORMATION

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

- ***Attach copy of the 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 Assets (IRA, 401(k), 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

E . Non-Retirement Investments (Stocks, Bonds, Annuities, Life Insurance, mutual funds, 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. 4/2007

OTHER INFORMATION

- **Please provide any additional information (financial or other) that would assist in evaluating your request for assistance. (Page 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**
    - **Copies of your paycheck stubs or a written statement from your employer showing earnings for the past twelve (12) months**
    - **Copy of last year's tax return**
    - **Copies of the most recent statement(s) showing balance in each bank account(s)**
    - **Copies of the most recent statement(s) showing value of each investment listed**

Mail to:
St. Luke's Hospital
Financial Counselor Office 1 West
915 East First Street
Duluth, MN 55805

Phone: 218-249-5340