Request for Financial Aid

Dear Patient:

In keeping with our mission, St. Luke's Medical Foundation is committed to providing financial aid to individuals who need help paying for required medical care and medications. This includes patients who have health insurance and those who do not.

If you are unable to pay for all or part of your health care services or prescriptions, you may apply for financial aid by completing and returning the attached form.

Please note that, in order for your application to be processed, you must provide the following:

- ☐ Information about your family, including the number of members in your household
- ☐ Information about your family's gross monthly income (income before taxes and deductions)
- ☐ Proof of income**
- ☐ A completed, signed and dated Financial Aid Application Form
- ☐ A letter of recommendation from your current physician or healthcare provider
- ☐ Additional information if needed

****Income Source Verification Required****
Please submit with your application copies of the following documents:

- 3 months of employment pay stubs
- Recent filed tax return for all family members
- Please provide proof of any other income source as listed on charity care application form

Mail or bring your completed application, along with all supporting documentation, to:

St. Luke's Medical Foundation
1101 Oakridge Drive, Suite B
Fort Collins, CO 80525

Please be aware that we cannot guarantee that you will be granted financial aid, even if you apply and qualify. Once you send in your application, we may ask for additional information or proof of income. By submitting a financial aid application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 30 calendar days of receiving a complete financial aid application, including documentation of income. If you have any questions about how to complete this form, please contact us at 970-223-1199.

Financial Aid Application Form – Confidential

Please fill out all information completely. If it does not apply, write "N/A." Attach additional pages if needed.

PATIENT AGREEMENT
I understand that St. Luke's Medical Foundation may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial aid. I affirm that the above information is true and correct to the best of my knowledge. I understand that if the information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided. _____ _____ Signature of Person Applying Date

SCREENING INFORMATION
Has the patient applied for Medicaid? □ **Yes** □ **No**
Does the patient receive state public services such as SNAP, TANF or WIC? □ **Yes** □ **No**
Is the patient currently homeless? □ **Yes** □ **No**
Is the patient's medical care need related to a car accident or work injury? □ **Yes** □ **No**

PATIENT AND APPLICANT INFORMATION			
Patient First Name	Patient Middle Name	Patient Last Name	
□ Male □ Female □ Other (may specify _____)	Birth Date	Social Security Number**	
Personal Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number**
Mailing Address _____ _____ City State Zip Code		Main contact number(s) ( ) _____ ( ) _____ Email Address: _____	
Employment status of person responsible for paying bill □ **Employed** (date of hire: _____) □ **Unemployed** (how long unemployed:_____) □ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)			

**NOTE: You do not have to provide a Social Security number to apply for financial aid. However, if you do provide us with your Social Security number, it will help speed up the processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "N/A."

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage or adoption who live together.

FAMILY SIZE _____ *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	If 18 years or older: Employer(s) name or source of income	1f 18 years or older: Total gross monthly income	Also applying for financial aid?
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:
- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work Study programs (students) - Pension - Retirement account distributions - Other (please explain _____)

INCOME INFORMATION

REMEMBER: You must include proof of income with your application.

You must provide information on your family's income. Income verification is required to determine financial assistance. <u>All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written, signed statement describing your income. Please provide proof for every identified source of income. Examples of proof of income include:</u>

- A "W-2" withholding statement; or
- Current pay stubs (3 months); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as financial hardship, seasonal or temporary income, or personal loss.