St Luke's
UNIVERSITY HEALTH NETWORK

Charity Care Application

V1

_____ Guarantor ID

_____ MedRec Num.

- A separate application is required for each member of the household who are requesting financial assistance, including minor children. Only one set of supporting documentation is needed per household.
- You must complete all pages of the application form.
- If you need help call your local St. Luke's Hospital Location and ask for the Financial Counselors Office.

Last/First Name:	Social Security#	Date of Birth:
Mailing Address:	City:	St: Zip Code:

Phone#	Message Phone# (Appt Reminders)	Do You have Health Insurance? **Yes No** If yes please list insurer and insurance ID #:
Have You Applied to Pennsylvania Medicaid within the last year? **Yes No Unsure**	Circle One: **Have PA Medicaid** **Denied PA Medicaid Did Not Apply**	

It is necessary for St. Luke's University Health Network (SLUHN) to ask personal questions in order to determine if you are eligible for this financial assistance. This information will be kept on file in strict confidence. You must verify your income when you apply, copies of your yearly federal income tax return, payroll check stubs covering the last 3 months, Social Security benefit statements or other income sources are required. We cannot use bank statements for this purpose. Your annual income and household size will be used to determine your financial assistance.

I declare the above information is true and give SLUHN permission to investigate any information in this application.

I understand that:

- My information will be held in strict confidence.
- If this information is found to be false, I will lose my eligibility for the program and be liable to repay any benefit I have received.
- If my income or household size changes, I am required to notify the Billing Department as soon as possible.
- This application is to be returned before my next appointment or within 30days, whichever is sooner, complete with proof of my annual income or this application will expire.
- If I am found to be eligible for reduced fees but failed to make required payments, my account may be sent to a collection agency.
- The timeframe of this application maybe extended or reduced at the discretion of SLUHN based on medical needs as assessed be SLUHN.

I do hereby swear and attest that all the information above about me is true and correct

Patient Signature:	Date: / / 20
Parent/Legal Guardian Signature:	Date: / / 20

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Complete signed application for each applicant, listing all household members and income sources

Proof of income for each income source

If you have very low or no income, complete the "Zero Income Worksheet" (Must be requested from Financial Counselor)

If you can not provide proof of income, complete the "Declaration of Income Statement" (Must be requested from Financial Counselor)

Most recent federal tax return if you file taxes

Checking/Savings/Money Market account statements for the last 3 months for income/resources verification

HOUSEHOLD: Please list all names and date of births for all members of your household including yourself.

If you file taxes your household is you, your spouse and any dependents you claimed on your taxes.

If you are claimed as a dependent by someone else, your household is you, the person who claims you and anyone else listed on their tax return.

If you do not file taxes and are not claimed as a dependent by anyone else, your household is you and your spouse and children if they live with you.

INCOME: You need to provide proof of income for each of the following sources of income for each member of your household to see if you qualify. Please note that we cannot accept bank statements as proof of income.

Employed: Pay stubs for the last 3 Months OR federal tax return

Self-employment and Rental Income: you must provide a copy of your most recent federal tax return

Current Benefit Statement for:

Unemployment **Social Security** **TANF** **Worker's Compensation**
Long or short term disability **Child support/Alimony** **Retirement pension and or annuity**

Last Name	First Name	Date of Birth	Gross Income before Taxes and deductions	Relation	Income Source With Proof Attached
			$__ __ __,__ __._ _	Self	
			$__ __ __,__ __._ _		
			$__ __ __,__ __._ _		
			$__ __ __,__ __._ _		
			$__ __ __,__ __._ _		
			$__ __ __,__ __._ _		
			$__ __ __,__ __._ _		
			$__ __ __,__ __._ _		
			$__ __ __,__ __._ _		

By signing below I declare that data and information listed above is accurate and true to the best of my knowledge and ability. I also certify that I have included all supporting documentation for each income source.

Patient Signature:	Date: / / 20
Parent/Legal Guardian Signature:	Date: / / 20

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Application Check List

V1

_____ Guarantor ID

_____ MedRec Num.

Application Date: _____/_____/_____ Financial Counselor: _____

First Review: _____/_____/_____ Second Review: _____/_____/_____ Third Review: _____/_____/_____

Item	Complete	Incomplete
Information is not legible Specify Page#		
Page 1 is not signed or is incomplete		
Page 2 is not signed or is incomplete		
3 months of pay stubs		
Federal Tax Return		
Bank Statements for Checking/Savings/Money Market for income verification		
Self-employed/Rental Income or Schedule C tax form		
Unemployment, SSI, TANF, Workers Comp, Disability, Child/Alimony Support, Retirement/Pension and or annuity		
Person completing the form did not sign attestation		
Other Housing is checked but no explanation provided		
Cell phone is marked yes but no explanation as to who pays for it		
Brief description of financial situation is not complete		
Below to be completed by Financial Counselor:		
Photo Id Scanned into EPIC		
Insurance Card(s) Scanned into EPIC		
Application Status updated in EPIC		
Application Scanned Into EPIC		

This Application has been:

_____ Approved as of _____/_____/_____, application expires on: _____/_____/_____

_____ Denied as of _____/_____/_____ because of:

_____

_____

I have reviewed this information and based the decision above soley on the information contained in this applciation

Counselor Signature:	Date: / / 20