



P.O. Box 2578
Boise, Idaho 83701

The completed application is used to determine your eligibility for our financial care programs or to establish a mutually agreeable payment arrangement.

When submitting your application, please include the following **(Do not send originals)**:

- A copy of last year's Federal Tax Return
- A copy of your most recent pay stub
- A copy of your bank statement from this month
- A copy of your W-2's
- If receiving public or other assistance, please provide documentation

Please return requested information within 2 weeks. St. Luke's will send written notification of the determination within 3 weeks of receiving your paperwork. If you would like to discuss your financial situation in person please call 208-706-5618 to schedule an appointment.

If this information is not returned your account will continue to flow through St. Luke's collection procedures until we arrive at a mutually agreeable determination.

St. Luke's Patient Financial Services is located at: 1500 Shoreline Dr., Boise



A Message about our Privacy Policy

Legislation requires us to inform you on how we obtain and protect nonpublic personal information about you which we acquire from the following sources:

- Information we receive from you on applications or other forms you complete;
- Information about your transaction with us, our affiliates, or others, such as your payment history or your account balances;
- Information we received from a consumer reporting agency; and
- Information we obtain from others in the process of verifying information you provide us.

We do not disclose your nonpublic personal information to anyone, except as permitted by law.



190 East Bannock Street
Boise, ID 83712
Attn: Financial Services

Treasure Valley Wood River Magic Valley
 St. Luke's Clinic(s): _____

FINANCIAL CARE APPLICATION

Patient Name:		Date of Birth:	
Responsible Party Name:		Marital Status:	
Address:		City:	
		State:	Zip:
Social Security#:	Date of Birth:	Phone:	
Employer:	Phone:	Hire Date:	
Address:		City:	
Previous Employer:		State:	Zip:
Spouse Name:		Social Security#:	Date of Birth:
Employer:	Phone:	Hire Date:	
Dependants: (List Members in Household-for additional members attach a separate sheet)			
Name	Age	Relationship	

Have you applied for Medicaid and been denied?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you asked for assistance from your family?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
How much are you able to pay each month?	\$ _____			

MONTHLY INCOME INFORMATION:		
The following income sources are required for verification:		
W-2 forms, income tax statements, check stubs or check statements. If self-employed, a financial statement is required.		
SOURCE OF INCOME	RESPONSIBLE PARTY	SPOUSE
Wages (before deductions)	\$	\$
Child Support/Adult Support/Alimony	\$	\$
Disability/Worker's Compensation	\$	\$
Pension	\$	\$
Social Security Income	\$	\$
Dividends/interest/Income	\$	\$
Rental Income	\$	\$
Estate/Trust Income	\$	\$
Public Assistance	\$	\$
Food Stamps	\$	\$

Other	\$	\$
Less FICA/State/Federal Taxes:	\$	\$
Less any other Deductions:	\$	\$
MONTHLY INCOME TOTAL:	\$	\$

ASSETS / RESOURCES	RESPONSIBLE PARTY	SPOUSE
Checking Account	\$	\$
Savings Account	\$	\$
Stocks / Bonds / CDs / IRA / 401K / Retirement	\$	\$
ASSETS / RESOURCES TOTAL:	\$	\$

Have you ever filed bankruptcy? Yes No *If yes, enter Year: _____ and Chapter: _____*
 Payment amount (if applicable): \$ _____

ALL REAL PROPERTY / VEHICLES	BALANCE	MONTHLY PAYMENT
Residence: <input type="checkbox"/> Own <input type="checkbox"/> Rent	\$	\$
Other property (list)	\$	\$
Vehicle #1: Model: _____ Year: _____	\$	\$
Vehicle #2: Model: _____ Year: _____	\$	\$
Recreational Vehicle: Model: _____ Year: _____	\$	\$
Other Vehicle: Model: _____ Year: _____	\$	\$
All Real Property / Vehicles Subtotal:	\$	\$

MEDICAL EXPENSES	BALANCE	MONTHLY PAYMENT
Hospital (name):	\$	\$
Hospital (name):	\$	\$
Hospital (name):	\$	\$
St. Luke's Physician Clinic (name):	\$	\$
St. Luke's Physician Clinic (name):	\$	\$
St. Luke's Physician Clinic (name):	\$	\$
Physician (name):	\$	\$
Physician (name):	\$	\$
Prescriptions:	\$	\$
Medical Expenses Subtotal:	\$	\$

CREDITORS	BALANCE	MONTHLY PAYMENT
Credit Card	\$	\$
Credit Card	\$	\$
Credit Card	\$	\$
Credit Card	\$	\$
Credit Card	\$	\$
Student Loan	\$	\$
Other Loan / Creditor	\$	\$

Other Loan / Creditor	\$	\$
Creditors Subtotal:	\$	\$

OTHER MONTHLY EXPENSES	BALANCE	MONTHLY PAYMENT
Groceries	\$	\$
Auto Insurance	\$	\$
Gasoline / Auto Maintenance	\$	\$
Health Insurance (if not deducted from payroll)	\$	\$
Utilities: Heating Fuel	\$	\$
Home Phone	\$	\$
Cell Phone	\$	\$
Water / Sewer / Trash	\$	\$
Electricity	\$	\$
Cable TV	\$	\$
Internet	\$	\$
Life Insurance	\$	\$
Renter / Homeowner Insurance (if not included in mortgage)	\$	\$
Child Support and/or Day Care	\$	\$
Clothing	\$	\$
Charitable Contributions	\$	\$
Other: _____	\$	\$
Other Monthly Expenses Subtotal:	\$	\$

MONTHLY FINANCIAL SUMMARY	BALANCE	MONTHLY PAYMENT
Monthly Income Totals (include spouse) from page 3:	\$	
Monthly payments on all real property / vehicles from page 3:▶	\$
Monthly medical expenses from page 3:▶	\$
Monthly payments to creditors from page 4:▶	\$
Other monthly expenses from page 4:▶	\$
TOTAL MONTHLY EXPENSES:▶	\$
NET DIFFERENCE:	\$	

If expenses are more than the income listed, please describe how expenses are met each month:

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I hereby state that the information I have provided is true and complete. I authorize the hospital to verify this information, including requesting a Credit Bureau Report when necessary. I understand that if any of this information is determined to be deceptive or false, I may be denied special financial consideration and I will be liable for any and all charges incurred for services rendered.

_____ Date

Responsible Party

For PFS Use Only: Guarantor Number(s):

Patient Name: