Financial Assistance Forms

Saint Luke's Health System

Financial Assistance Application

Account (s) #:_____

_____ _____-_____-_____ _____/_____/_____
Responsible Party or Guarantor Social Security Number DOB: Month Day Year

_____ _____ _____
Home Address City State Zip Code

(___)_____-_____ (___)_____-_____ (___)_____-_____
Home Phone Number Cell Phone Number Work Phone Number/Other

_____ _____-_____-_____ _____/_____/_____
Patient's Name Social Security Number DOB: Month Day Year

Patient's Relationship to Applicant: ☐ Self ☐ Spouse/Partner ☐ Parent/Legal Guardian ☐ Child
☐ Other (please specify):_____

Total Household Size: List the dependents who reside in the applicant's house for whom the applicant takes financial responsibility. Check the appropriate relationship box for each dependent.

			Relationship			
Name		**Age**	**Spouse/Partner**	**Parent**	**Child**	**Other**
1.	_____	_____	☐	☐	☐	☐
2.	_____	_____	☐	☐	☐	☐
3.	_____	_____	☐	☐	☐	☐
4.	_____	_____	☐	☐	☐	☐
5.	_____	_____	☐	☐	☐	☐
6.	_____	_____	☐	☐	☐	☐

Have you been a resident of Kansas City area for the last 3 years? ☐ Yes ☐ No

Total Gross Monthly Income for the last 30 days: Total Savings and Investments:

Sources of Income	Applicant/Patient	Spouse/Live-in Partner	Source	Applicant/Patient	Spouse/Live-in Partner
Wages	$	$	Bank Accounts	$	$
Social Security Payment	$	$	Savings	$	$
Unemployment Benefits	$	$	Stocks/Bonds	$	$
Disability Payment	$	$	CD's	$	$
Workers' Compensation	$	$	IRA's	$	$
Alimony/Child Support	$	$	Other	$	$
Dividends, Interest, Rental	$	$			
Food Stamps, Govt. Assist.	$	$			
Other					

Patients at approved National Health Services Corps (NHSC) sites, do not have to provide Social Security Numbers, banking and assets information or check the residency box on this application.

Return completed application with prior year tax return, bank statements for last two months and last two paycheck stubs. If you have special circumstances you would like considered please attach a separate letter with the explanation.

By my signature below, I certify that the information and documentation provided is an accurate and complete statement of my current financial position and give my permission to verify this information. My failure to pay any reduced or adjusted balance will subject me to the normal billing and collection practices of Saint Luke's Health System.

Signature of Patient/Applicant:_____ Date:_____ Time:_____

Patient Label:

Saint Luke's Health System

Financial Assistance Application

Instructions for Completing the Financial Assistance Application:

Below is a description of each field on the Financial Assistance Application. If you have any additional questions or need assistance in completing this application, please contact the business office for the entity at which the services were received.

Saint Luke's Hospitals: Plaza, North, South, East, Anderson, Hedrick, & Wright Locations	888-581-9401
Saint Luke's Physician Services	816-502-7000
Saint Luke's Home Care & Hospice	816-756-1160
Allen County Regional Hospital	620-365-1015

Responsible Party or Guarantor: Person responsible for the balance of the bill. Any person 18 years of age or older at the time the service was provided will be their own guarantor. Exceptions to this rule are those with legal guardians, patients receiving certain medical services and the surviving spouse of a deceased patient.

Social Security Number: Social security number of responsible party
DOB: Date of birth of responsible party
Home Address: Home address (including city, state, zip code) of responsible party
Home, Cell, Work Phone Numbers: Phone numbers of responsible party

Patient's Name: Name of patient if different from responsible party or guarantor
Social Security Number: Social security number of patient
DOB: Date of birth of patient
*If the patient is the same as the responsible party or guarantor, these fields can be left blank

Patient's Relationship to Applicant: Indicate the relationship of the person applying for assistance to the patient

Total Household Size: List dependents who reside in the applicant's house for whom the applicant takes financial responsibility. Indicate the relationship of the dependent by marking the applicable box.

Have you been a resident of the Kansas City are for the last 3 years? This is for informational purposes only and does not impact the outcome of the application.

Total Gross Monthly Income for the last 30 days: Please indicate the monthly income amount in the appropriate source of income box(s) for the applicant/patient and spouse/live-in partner if applicable. If your source of income is not listed, please list in the "other" source.

Total Savings and Investments: It is required to report all savings and investments to provide a full financial picture. Please list the balance of each savings and investment source in the appropriate box.

If you need assistance completing the form, please call us at a number listed above. Thank you.

Please return the completed application to the address of the entity in which you are applying for assistance:

Saint Luke's Hospitals (Plaza, North, South, East, Anderson, Hedrick & Wright) and Physician balances for Anderson, Hedrick & Wright:
Saint Luke's Health System, 901 E 104th St, Attn: Hospital CBO 7th Floor, Kansas City, MO 64131

Saint Luke's Physician Services:
Saint Luke's Physician Services, 901 E 104th St, Attn: Physician CBO 4th Floor, Kansas City, MO 64131

Saint Luke's Home Care & Hospice:
Saint Luke's Home Care & Hospice, 901 E 104th St, Attn: Home Care & Hospice 7th Floor, Kansas City, MO 64131

Allen County Regional Hospital:
Allen County Regional Hospital, 3066 N Kentucky St. PO Box 540, Iola, KS 66749

Patient Label: