St. Luke's Health System

Financial Care Application

Residents of the following states are eligible:
ID, OR, NV, UT and WA

St. Luke's provides financial assistance for qualifying patients who need help paying for some or all emergency or medically necessary care they received in a St. Luke's facility or by a St. Luke's provider. Patients who are unable to pay for all or part of their health care services may apply for assistance by completing a signed Financial Care Application and submitting requested documents. Patients and families who meet certain income requirements may qualify for discounted care based on their family size and income, even if you have health insurance.

Services that are eligible for external financial assistance options (e.g., Affordable Care Act (ACA) Healthcare Marketplace, government assistance or state/federal agency plans) may *not* be eligible for internal financial care.

≤ 400% GROSS 2025 Federal Poverty Guidelines										
Family Size:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Monthly:	**$5,216.67**	**$7,050**	**$8,883.33**	**$10,716.67**	**$12,550**	**$14,383.33**	**$16,216.67**	**$18,050**	**$19,883.33**	**$21,716.67**
Annually:	**$62,600**	**$84,600**	**$106,600**	**$128,600**	**$150,600**	**$172,600**	**$194,600**	**$216,600**	**$238,600**	**$260,600**

To view our financial care policy and discount guidelines, visit St. Luke's Online: https://www.stlukesonline.org

Patients submitting a Financial Care Application for services received at St. Luke's must submit the below items to determine if you meet eligibility requirements for financial assistance.

Please include copies of the documents requested below:

Pay stubs: Copies from the past 30 days for all household members.

Tax documents: Current year Federal Tax return with W-2(s), or if taxes have *not* been filed a W-2(s) plus Form 4868 "Automatic Extension to file U.S. Individual Income Tax Return."

Proof of Income: Documentation for all income sources (e.g., rental, disability, unemployment) for all household members 18+ years old. For pension, dividends or trust, documentation is only required to support proof of income.

Bank statements: Most recent, showing all transactions (deposits and withdrawals) for all accounts, only required if used to support proof of income.

Self-employed: Schedule C, 3 months of profit and loss (PnL) statements, and bank statements.

Public assistance: Documentation of benefits (e.g., food stamps, cash assistance, etc.).

Social Security: Determination letter.

No income: Written explanation of how expenses are covered.

Please mail, fax, or email your application along with all required supporting documentation:

St. Luke's Health System
Financial Care
P.O. Box 2578
Boise, ID 83701

Fax: (208) 706-7619 Attention: Financial Care

Email: pfsfincare@slhs.org Subject: Financial Care

Upon receiving a complete application and required documents, St. Luke's will place all self-pay balances on hold and mail a determination letter after review. Incomplete applications will result in a 30-day hold pending submission of missing documents.

If you would like to discuss your financial situation, please contact a Patient Financial Advocate at (208) 706-6229 or email pfsfincare@slhs.org.

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Applicant/Co-Applicant

'Applicant' (primary contact)		'Co-Applicant' (spouse, significant other or domestic partner etc.)	
Applicant Name:		**Co-Applicant Name:**	
Social Security Number:	**Date of Birth:**	**Social Security Number:**	**Date of Birth:**
Phone:	**Email:**	**Phone:**	**Email:**
Address:			

List of Household Members

Name	Date of Birth	Relationship to Applicant

Employment/ Income

Please provide Gross Monthly Income details (prior to deductions) for Applicant/Co-Applicant and include all supporting documentation. If employment is seasonal, enter your Annual Gross Income (AGI).

Applicant		Co-Applicant	
Employer or Business Name: **Hire Date:**		**Employer or Business Name:** **Hire Date:**	
Employment/Self Employment: **Annual ☐ Monthly ☐ Seasonal ☐**	**$**	**Employment/Self Employment:** **Annual ☐ Monthly ☐ Seasonal ☐**	**$**
Child/Adult Support/Alimony:	**$**	**Child/Adult Support/Alimony:**	**$**
Social Security/Disability:	**$**	**Social Security/Disability:**	**$**
Public Assistance/ Food Stamps/ Unemployment etc.:	**$**	**Public Assistance/ Food Stamps/ Unemployment etc.:**	**$**
Retirement/Pension/Social Security Retirement:	**$**	**Retirement/Pension/Social Security Retirement:**	**$**
Rental Property Income:	**$**	**Rental Property Income:**	**$**
Income from other sources Describe:	**$**	**Income from other sources Describe:**	**$**

Disclosure and Signature

By signing and submitting this application to St. Luke's, I certify that all the information I provided is true and complete to the best of my knowledge. I hereby authorize St. Luke's Health System to investigate any statements or data given by me or any person pertaining to my financial responsibility. If I knowingly and with intent to defraud or deceive, or provide false information, I will be denied financial assistance for current and future services and will be liable for all charges. We reserve the right to verify all information provided on this application by any means available to us.

Applicant Signature: _____ **Date:** _____

Co-Applicant Signature: _____ **Date:** _____