



Dear Patient:

The Saint Luke's Health System is dedicated to helping our patients. It is our understanding you are requesting financial assistance with your account(s). Enclosed is a Statement of Financial Position for you to complete. **It is important that you provide us with all required information. Please return the items indicated below:**

Financial Assistance Application

Income Tax Return for most recent year (signed copy with all schedules & forms)

Bank statements for last two months

Other: _____

The decision to provide financial assistance is based on income and special circumstances affecting your financial status. Please be specific when completing Part H of the statement of Financial Position. Any and all information you provide will be considered in making this decision.

Please return your completed application within fourteen (14) days in the enclosed postage paid envelope. Due back by _____

Patient Accounts Department
Saint Luke's Hospital
P.O. Box 119000
Kansas City, MO 64171-9960

After reviewing your financial situation, we will notify you of our decision. If you have any questions regarding this application please call me. I will be happy to assist you.

Sincerely,

Patient Accounts
816-932-5678
888-581-9401 (toll free)
816-932-6207 (fax)

4401 Wornall Road, Kansas City, MO 64111 • Phone (816) 932-2000

Not a Part of the Permanent Medical Record



Saint Luke's Health System
Statement of Financial Position

Account Number _____

PART A - PATIENT INFORMATION

Patient's Full Name _____ Social Security Number _____

Address (Number and Street, City, State, Zip Code) _____ Phone Number () _____

Marital Status: [] Single [] Married [] Divorced [] Separated [] Widowed

Name and Address of Employer _____ Phone Number of Employer () _____

Occupation _____ Length of Employment _____ GROSS Monthly Salary _____

If not presently employed, name and address of last Employer _____ Occupation _____

Patient's Bank (Name and Branch Address) _____
Checking: Balance \$ _____
Savings: Balance \$ _____

PART B - RESPONSIBLE PARTY INFORMATION (Spouse, Parent, Guardian, etc.) If same as patient, go to PART C

Full Name of Person Responsible for the Bill _____ Relationship to Patient _____

Address (Number and Street, City, State, Zip Code) _____ Phone Number () _____

Name and Address of Employer _____ Phone Number of Employer () _____

Occupation _____ Length of Employment _____ GROSS Monthly Salary _____

If not presently employed, name and address of last Employer _____ Occupation _____

Responsible Party's Bank (Name and Branch Address) _____
Checking: Balance \$ _____
Savings: Balance \$ _____

PART C - PATIENT AND RESPONSIBLE PARTY'S ASSETS

HOUSING INFORMATION [] Own [] Rent
[] If Owned, value of house/land Value \$ _____ Loan Balance \$ _____
[] Other Property Value \$ _____ Loan Balance \$ _____
[] Stocks/Bonds Value \$ _____
[] Certificates of Deposit Value \$ _____
[] IRAs/Retirement Fund Value \$ _____
[] Other Value \$ _____

PART D - (FOR INFORMATION ONLY) RESIDENCY IS NOT A REQUIREMENT FOR FINANCIAL ASSISTANCE

Have you been a resident of Kansas City area for the preceding 3 years?
[] YES [] NO

PART E - DEPENDENTS

Dependents (not including self) living in your household.
Name Relationship Age

