1000 Bower Hill Road | Pittsburgh, PA 15243 | tel 412.942.4000 | www.stclair.org

Dear Patient or Responsible Party,

In an effort to provide financial assistance to members of our community, St. Clair Hospital has a Financial Assistance program in place for uninsured patients or patients with high balances after insurance. The Financial Assistance Program at St. Clair Hospital may be able to assist you with expenses incurred from the services received during your recent visit.

To see if our program can assist you please review the enclosed packet which outlines the requirements of the St. Clair Hospital Financial Assistance guidelines. Please review carefully and supply all requested information. All information is kept private and is used only for the evaluation of your application for the St. Clair Hospital Financial Assistance Program. Applications submitted without complete information will be denied.

Please return the completed application within 10 days of the receipt of this packet. You will continue to receive bills until your application process is completed. Upon verification of income and assets and completing the application process, a written determination will be mailed within three (3) working days of your eligibility.

If you have any questions regarding the St. Clair Hospital Financial Assistance Program application please contact our staff between 8:30 AM to 4:00 PM Monday through Friday call St. Clair Hospital at 412-942-8157.

Thank you for choosing St. Clair Hospital as your healthcare provider.

Sincerely,

St. Clair Hospital Financial Assistance Staff
1000 Bower Hill Road
Pittsburgh, PA 15243

ST. CLAIR HOSPITAL
CHARITY CARE FINANCIAL ASSISTANCE PROGRAM
QUALIFYING GUIDELINES

Charity Care is granted to patients whose credit score is less than the hospital's current threshold of 450. Program guidelines (for patients with credit score greater than the hospital's threshold of 450) based on The Department of Health and Human Services Federal Poverty guidelines: Federal Register, Vol. 76, No. 13, January 20, 2011, pp. 3637-3638

FAMILY INCOME MAXIMUMS

FAMILY SIZE	DISCOUNT 100%	DISCOUNT 30%	DISCOUNT 20%
1	$21,780	$27,225	$32,670
2	$29,420	$36,775	$44,130
3	$37,060	$46,325	$55,590
4	$44,700	$55,875	$67,050
5	$52,340	$65,425	$78,510
6	$59,980	$74,975	$89,970
7	$67,620	$84,525	$101,430
8	$75,260	$94,075	$112,890

each additional family member $3,820

ST. CLAIR HOSPITAL
APPLICATION FOR FINANCIAL ASSISTANCE / CHARITY CARE
DEMOGRAPHICS AND SCREENING

Medical Record # ____________

Account # ____________

Patient SS # ____________

Patient DOB ____________

Date Of Service ____________

Inpatient ☐ yes ☐ no

Amt w/o to Charity Care ____________

TU Soft Score ____________

Reviewed by CSR Date

(For Customer Service Personnel)

PATIENT DEMOGRAPHIC

Patient Name ____________

Patient Phone # ____________

Patient Address ____________

____

____

GUARANTOR DEMOGRAPHIC

Guarantor Name ____________

Guarantor Phone # ____________

Guarantor Address ____________

____

____

(**PLEASE NOTE**: If Guarantor is the same as Patient enter SAME)

MEDICAL ASSISTANCE SCREENING

Are you a citizen of the United States? ☐ yes ☐ no
If NO, are you a permanent resident, legally residing in the US*? ☐ yes ☐ no
*(If patient is a permanent resident, provide a copy of official documentation)
Are you PREGNANT or was the admission pregnancy related? ☐ yes ☐ no
Do you have a pending or approved MEDICAID application? ☐ yes ☐ no
Are you legally DISABLED or potentially DISABLED for 12 months? ☐ yes ☐ no
Are you legally BLIND? ☐ yes ☐ no
Are you a VICTIM OF CRIME? ☐ yes ☐ no
Do you have a DEPENDENT CHILD living with them? ☐ yes ☐ no
Do you have PRIVATE MEDICAL INSURANCE? ☐ yes ☐ no

If **YES**, please provide the following:

Name of Insurance Company ____________

Policy Number ____________

Group Number ____________

Policy Holder Name ____________

Name of Employer ____________

Address ____________

ST. CLAIR HOSPITAL
APPLICATION FOR FINANCIAL ASSISTANCE / CHARITY CARE
HOUSEHOLD DEMOGRAPHICS - INCOME - EXPENSE SUMMARY

Marital Status:
SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐

HOUSEHOLD DEMOGRAPHIC

Line	List all household member names	Date of Birth	Social Security Number	Relationship to Guarantor	US Citizen
1	PATIENT			SELF	
2					
3					
4					
5					
6					

HOUSEHOLD INCOME

Line	Name - Who Is Earning Income	Monthly Gross Income (From Pg 5 worksheet)	Employer Name (if income is from wages)
1	PATIENT	$	
2		$	
3		$	
4		$	
5		$	
6		$	
	Total Monthly Household Income:	$	

HOUSEHOLD MEDICAL EXPENSES

Line	Name - Who Is Occurring Expense	Monthly Medical Expense (From Pg 6 worksheet)
1	PATIENT	$
2		$
3		$
4		$
5		$
6		$
	Total Monthly Household Medical Expense:	$

ST. CLAIR HOSPITAL
APPLICATION FOR FINANCIAL ASSISTANCE / CHARITY CARE
HOUSEHOLD COUNTABLE ASSESTS SUMMARY

HOUSEHOLD CHECKING / SAVINGS ASSESTS

Line	Household Member	Bank / Institutional	Account Type (Checking or Savings)	Account Number	Balance
1	PATIENT				
2	PATIENT				
3					
4					
5					
6					

HOUSEHOLD COUNTABLE (NEGOTIABLE) ASSESTS

Line	Household Member	Bank / Institutional	Account Type	Balance (From Pg 7 worksheet)
1	PATIENT			
2				
3				
4				
5				
6				

REAL ESTATE ASSESTS (other than primary residence)

Line	Household Member	Bank / Institutional	Balance	Estimated Property Value	Address
1	PATIENT				
2					
3					
4					
5					
6					

ST. CLAIR HOSPITAL
APPLICATION FOR FINANCIAL ASSISTANCE / CHARITY CARE
INCOME INFORMATION WORKSHEET

MONTHLY INCOME SOURCE	PATIENT	HOUSEHOLD MEMBER 2	HOUSEHOLD MEMBER 3	HOUSEHOLD MEMBER 4
Wages / Salary / Tips				
(please indicate weekly, monthly etc.)				
Child Support				
Dividend Income				
Interest Income				
IRA, Stocks, Bonds				
Pension				
Rental Income				
Self-Employment Income				
Social Security				
SSI (Supplemental Security Income)				
Trust payments				
Unemployment Compensation				
Workers Compensation				
Other				
TOTAL MONTHLY INCOME	Enter on Pg3 Line 1 Under Household Income	Enter on Pg3 Line 2 Under Household Income	Enter on Pg3 Line 3 Under Household Income	Enter on Pg3 Line 4 Under Household Income

ST. CLAIR HOSPITAL
APPLICATION FOR FINANCIAL ASSISTANCE / CHARITY CARE
MEDICAL EXPENSE WORKSHEET

MONTHLY MEDICAL EXPENSE	PATIENT	HOUSEHOLD MEMBER 2	HOUSEHOLD MEMBER 3	HOUSEHOLD MEMBER 4
Doctors Visits				
Health Insurance Premiums				
Home Health Care				
Hospital Services				
Medical Equipment				
Nursing Home - Skilled Care				
Prescriptions				
Private Duty Nursing				
Other				
TOTAL MONTHLY MEDICAL EXPENSE	*Enter on Pg3 Line 1 Under Medical Expense*	*Enter on Pg3 Line 2 Under Medical Expense*	*Enter on Pg3 Line 3 Under Medical Expense*	*Enter on Pg3 Line 4 Under Medical Expense*

ST. CLAIR HOSPITAL
APPLICATION FOR FINANCIAL ASSISTANCE / CHARITY CARE
HOUSEHOLD COUNTABLE (NEGOTIABLE) ASSESTS

HOUSEHOLD COUNTABLE ASSESTS	PATIENT	HOUSEHOLD MEMBER 2	HOUSEHOLD MEMBER 3	HOUSEHOLD MEMBER 4
Stocks				
Bonds				
Certificate of Deposit				
U.S. Savings Bonds				
Health Savings Account (HSA)				
Savings Certificate				
Christmas or Vacation Club				
Other				
TOTAL HOUSEHOLD COUNTABLE ASSESTS	*Enter on Pg4 Line 1 Under COUNTABLE ASSESTS*	*Enter on Pg4 Line 2 Under COUNTABLE ASSESTS*	*Enter on Pg4 Line 3 Under COUNTABLE ASSESTS*	*Enter on Pg4 Line 4 Under COUNTABLE ASSESTS*

ST. CLAIR HOSPITAL
APPLICATION FOR FINANCIAL ASSISTANCE / CHARITY CARE
AFFIDAVIT

I swear (or affirm) that all the information indicated on this form is true, correct and complete to the best of my ability, knowledge and belief. I agree to report to St. Clair Hospital, within one week, all changes in income, financial resources or other information indicated on this form which may affect my eligibility to receive Financial Assistance / Charity Care at St. Clair Hospital. I understand that my credit and other financial information may be referenced to verify my statement and eligibility for the program.

Fraudulent statements by the patient for the purpose of obtaining financial assistance will be forwarded to the Pennsylvania Department of Justice for Prosecution. Patients who falsify the Program application will no longer be eligible for the Program and will be held responsible for all charges incurred while enrolled in the Program retroactively to the first day that charges were incurred under the Program.

X ____ ______________

Applicant's Signature Date

ST. CLAIR HOSPITAL
APPLICATION FOR FINANCIAL ASSISTANCE / CHARITY CARE
RETURN DOCUMENT CHECKLIST

Complete the application. Be sure to **SIGN** where indicated by the **(X)** on page 8.
Enclose copies of the following document verifications for all family members if applicable.

Please sent to:

St. Clair Hospital
Patient Financial Services
1000 Bower Hill Road
Pittsburgh, PA 15243.

Failure to return all documents will mean a delay in processing or possible denial of application

- ☐ Proof of ALL income received for the three (3) month period prior to application for ALL family members indicated on page 5 of the *INCOME INFORMATION WORKSHEET*
- ☐ Most recent checking and savings account statements (all pages) for all family members indicated on page 4 of the *HOUSEHOLD DEMOGRAPHICS - INCOME - EXPENSE SUMMARY*

Proof of the value of all miscellaneous assets

- ☐ IRA's
- ☐ Stocks
- ☐ Trusts
- ☐ Bonds
- ☐ Proof of Real Estate owned (other than primary residence)
  - ☐ Financial Institution where mortgage is held
  - ☐ Original sales price - Estimated current value - Balance owed
  - ☐ Rental amounts for each unit if multiple units
- ☐ If patient is being supported by another party, please include a signed statement from that party indicating what type of support, how it is provided, the relationship to the patient and if monetary, the amount.
- ☐ If the patient is deceased, please provide a copy of the death certificate and a letter stating the status of the estate.
- ☐ Proof of ALL Medical Expenses
  - ☐ Copy of ALL bills and invoices
  - ☐ Proof of monthly, yearly or quarterly Insurance premiums
  - ☐ Proof of paid monthly perscriptions (if available)

If you have any questions, please call Customer Service between
8:30 AM to 4:00 PM Monday through Friday at 412-942-8158

ST. CLAIR HOSPITAL
APPLICATION FOR FINANCIAL ASSISTANCE / CHARITY CARE
ADDITIONAL INFORMATION OR COMMENTS

Please provide any additional information or comments