ST. CLAIR HEALTH
FINANCIAL ASSISTANCE PROGRAM

APPLICATION INSTRUCTIONS & QUALIFICATION GUIDELINES

Please fully complete the application and be sure to **SIGN** the affidavit statement on page 4.
Enclose copies of the following documents for all applicants.

Please send to: **St. Clair Health**
Financial Assistance
5000 Centregreen Way
SUITE 100
CARY, NC 27518

Failure to return all documents will either delay processing or cause the application to be denied. Please attach copies only as any documents submitted unfortunately cannot be returned.

☐ Please attach proof of **ALL** income received from the past 30 days prior to the submission of the application for the applicant and their spouse.

☐ **The most current** checking and savings account statements (all pages) prior to the submission of the application.

☐ If the patient is deceased, please provide a copy of the death certificate and a letter stating the status of the estate.

If you have any questions, please call Customer Service at 412-344-3408.
Monday-Friday 8:00 A.M. to 8:00 P.M. and Saturdays 8:00 A.M. to 12:00 P.M.

Financial Assistance is granted to patients whose credit score is less than the hospital's current threshold of 550. Program guidelines (for patients with credit score greater than the hospital's threshold of 550) are based on The Department of Health and Human Services Federal Poverty Guidelines: Federal Register / Vol. 88 / January 12, 2023, pp. 3424-3425

COMBINED FAMILY INCOME MAXIMUMS

FAMILY SIZE	DISCOUNT		
	100%	30%	20%
1	$29,160	$36,450	$43,740
2	$39,440	$49,300	$59,160
3	$49,720	$62,150	$74,580
4	$60,000	$75,000	$90,000
5	$70,280	$87,850	$105,420
6	$80,560	$100,700	$120,840
7	$90,840	$113,550	$136,260
8	$101,120	$126,400	$151,680

* each additional family member $5,140

FAMILY NET ASSETS>$10,000 WILL ALSO BE CONSIDERED ON A CASE BY CASE BASIS IN DETERMINING ELIGIBILITY.

ST. CLAIR HEALTH
APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT DEMOGRAPHICS

Patient Name ______________________________

Patient Phone # ______________________________

Patient Address ______________________________

____

HOUSEHOLD DEMOGRAPHICS

List all household members	Date of Birth	Relationship to Patient
		SELF

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 a full time student? ☐ yes ☐ no
Are you pregnant or was the admission pregnancy related? ☐ yes ☐ no
Do you have a pending or approved Medicaid application? ☐ yes ☐ no
Do you have medical insurance? ☐ yes ☐ no

HOUSEHOLD ASSETS-CHECKING AND SAVINGS ACCOUNTS

Account Type (Checking or Savings)	Bank / Institute	Balance

ST. CLAIR HEALTH
APPLICATION FOR FINANCIAL ASSISTANCE

OTHER HOUSEHOLD COUNTABLE ASSETS (EXCLUDE RETIREMENT ASSETS)

Type of Asset	Bank / Institute	Balance
Stocks/Bonds		
Certificate of Deposit		
U.S. Savings Bonds		
Health Savings Account (HSA)		
Savings Certificate		
Christmas or Vacation Club		

HOUSEHOLD DEBT/LOANS (EXCLUDE PRIMARY RESIDENCE MORTGAGE)

Type of Credit	Bank / Institute	Balance
Debt/Loans (Excluding Mortgage)		
Credit Card 1		
Credit Card 2		
Credit Card 3		
Other 1		
Other 2		
Other 3		

ST. CLAIR HEALTH
APPLICATION FOR FINANCIAL ASSISTANCE

MONTHLY GROSS INCOME

	PATIENT	HOUSEHOLD MEMBER 2	HOUSEHOLD MEMBER 3	HOUSEHOLD MEMBER 4
Wages / Salary / Tips				
Unemployment Compensation				
Social Security				
Child Support				
Self-Employment Income				
Interest/Dividend Income				
Pension				
Rental Income				
Trust payments				
Workers Compensation				
Other				

NOTE--If you have no income and are being financially supported by another person, please have them complete and sign the below statement:

____ currently has no income. I am currently supporting them with food, shelter and any clothing needs. I also give them financial help in the amount of $___________ on average per month.

X ____ ______________

Support Giver's Signature Date

AFFIDAVIT- ALL APPLICANTS MUST SIGN

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 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

Updated 1/21/22