



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.

Send documentation to: **St. Clair Health**
Financial Assistance
5000 Centregreen Way
Suite 100
Cary, NC 27513

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 contact Customer Service at 412-344-3408.

Monday to Friday from 8:00 a.m. to 8:00 p.m.

Financial assistance is granted to patients whose credit score is less than the hospital's current threshold of 550 or the requirements below are met. Program guidelines (for patients with credit scores above the hospital threshold of 550) are based on the Department of Health and Human Services Federal Poverty Guidelines: Federal Register / Volume 89 / January 17, 2024, pages 2961-2963

COMBINED FAMILY INCOME MAXIMUMS

| FAMILY SIZE | DISCOUNT | | |
|---------------------------------------|-----------|-----------|-----------|
| | 100% | 30% | 20% |
| 1 | \$30,120 | \$37,650 | \$45,180 |
| 2 | \$40,880 | \$51,100 | \$61,320 |
| 3 | \$51,640 | \$64,550 | \$77,460 |
| 4 | \$62,400 | \$78,000 | \$93,600 |
| 5 | \$73,160 | \$91,450 | \$109,740 |
| 6 | \$83,920 | \$104,900 | \$125,880 |
| 7 | \$94,680 | \$118,350 | \$142,020 |
| 8 | \$105,440 | \$131,800 | \$158,160 |
| Add for each additional family member | \$10,760 | \$13,450 | \$16,140 |

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 Number _____

Patient Address _____

HOUSEHOLD DEMOGRAPHICS

| List all household members | Date of Birth | Relationship with the 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 statement below:

_____ currently has no income. I am currently supporting them with food, shelter and 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 information on this form is true, correct, and complete to the best of my knowledge. I agree to notify St. Clair Hospital within one week of all changes in income, financial resources, or other information listed on this form that may affect my eligibility for Financial Assistance at St. Clair Hospital. I understand that my credit and other pertinent financial information may be consulted to verify the statement and my eligibility for the program.

Fraudulent patient statements made for the purpose of obtaining financial assistance will be referred to the Pennsylvania Office of Attorney General for appropriate 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 retroactive to the first day such charges were incurred under the Program.

X _____
Applicant's Signature _____
Date