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 90 / January 17, 2025, pages 5917-5918

COMBINED FAMILY INCOME MAXIMUMS

FAMILY SIZE	DISCOUNT		
	100%	30%	20%
1	$31,300	$39,125	$46,950
2	$42,300	$52,875	$63,450
3	$53,300	$66,625	$79,950
4	$64,300	$80,375	$96,450
5	$75,300	$94,125	$112,950
6	$86,300	$107,875	$129,450
7	$97,300	$121,625	$145,950
8	$108,300	$135,375	$162,450
Add for each additional family member	$11,000	$13,750	$16,500

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		

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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