

**Financial Assistance Policy**

**St. Vincent Hospital & St. Vincent Medical Clinic**

Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at St. Vincent Hospital/ Medical Clinic, for one calendar year from date of issue. The business office can provide you with further details. Please contact the business office at 719-486-7157 to make an appointment with our eligibility coordinator.

**Please provide the following:**

|  |  |
| --- | --- |
| Employed | Self Employed |
| * Tax Returns for previous year ***or***
* 2 current pay stubs from last calendar month for patient or spouse ***or***
* 1 month bank statement showing income
* Proof of ID for patient/guarantor:

Choose 1 from this group:Passport, State, Federal or other Country issued Photo I.D. or Green Card, School ID, Medicaid or CHP+ card. And* Second Form of ID

Choose 1 from this group:SS card, Birth Certificate, Visa, rent, utility receipts, etc. | * One Month of gross bank business deposits.
* Year-to-date- profit and loss statements or business ledgers
* Business taxes from previous year
 |

**If you are homeless please ask to speak to our Eligibility Coordinator**

**Provide proof of earned income if applicable:**

* UnemploymentDisability Benefits
* Worker’s Compensation Pensions or Retirement
* Social Security or Supplemental Interest or Dividends
* Security SSI Rents, Royalties, estates and trusts
* Public Assistance Alimony
* Veteran’s Benefits Survivor Benefits

**INCOME:**

|  |  |
| --- | --- |
| Household Member | Household Income (complete one column) |
| Annual | Monthly | Bi-Weekly |
| Self |  |  |  |
| Spouse |  |  |  |
| Dependent ChildrenUnder age 18 |  |  |  |
|  |  |  |  |
| Total:  |  |  |  |



**Household:**

Number of related persons living in your households: \_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Name of Head of Household | Place of Employment |
| Street | City | State | Zip | Phone |
| Health Insurance Plan | Social Security |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name**  | **Date of Birth** | **Name** | **Date of Birth** |
| Self |   | Dependent (under 18 years of age) |   |
| Spouse |   | Dependent (under 18 years of age) |   |
| Dependent (under 18 years of age) |   | Dependent (under 18 years of age) |   |
| Dependent (under 18 years of age) |   | Dependent (under 18 years of age) |   |

If more spaces is needed add names and dates of birth below:

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2023 HHS POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES**

Federally facilitated marketplaces will use the 2023 guidelines to determine eligibility for Medicaid.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Number of Persons in Household  | 100% | 133% | 138% | 150% | 200% | 300% | 400% |
| 1 |  $ 14,580  |  $ 19,391  |  $ 20,120  |  $ 21,870  |  $ 29,160  |  $ 43,740  |  $ 58,320  |
| 2 |  $ 19,720  |  $ 26,228  |  $ 27,214  |  $ 29,580  |  $ 39,440  |  $ 59,160  |  $ 78,880  |
| 3 |  $ 24,860  |  $ 33,064  |  $ 34,307  |  $ 37,290  |  $ 49,720  |  $ 74,580  |  $ 99,440  |
| 4 |  $ 30,000  |  $ 39,900  |  $ 41,400  |  $ 45,000  |  $ 60,000  |  $ 90,000  |  $ 120,000  |
| 5 |  $ 35,140  |  $ 46,736  |  $ 48,493  |  $ 52,710  |  $ 70,280  |  $ 105,420  |  $ 140,560  |
| 6 |  $ 40,280  |  $ 53,572  |  $ 55,586  |  $ 60,420  |  $ 80,560  |  $ 120,840  |  $ 161,120  |
| 7 |  $ 45,420  |  $ 60,409  |  $ 62,680  |  $ 68,130  |  $ 90,840  |  $ 136,260  |  $ 181,680  |
| 8 |  $ 50,560  |  $ 67,245  |  $ 69,773  |  $ 75,840  |  $ 101,120  |  $ 151,680  |  $ 202,240  |
|  |  |  |  |  |  |  |  |
|  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ADJUSTED FEDERAL POVERTY LEVEL | PATIENT RESPONSIBILITY (INPATIENT, OBSERVATION) | PATIENT RESPONSIBILITY (OUTPATIENT RECURRING, PHYSICIAN SERVICES, PHYSICAL THERAPY) | PATIENT RESPONSIBILITY (EMERGENCY) | PATIENT RESPONSIBILITY(LAB, RADIOLOGY, Screenings/Diagnostic) | ADJUSTMENT |
| 0–150% | 0% of charges | 0% of charges | 0% of charges | 0% of charges | 100% |
| 151–299% | 20% of charges | 20% of charges | 20% of charges | 20% of charges | 80% |
| 300–399% | 30% of charges | 30% of charges | 30% of charges | 30% of charges | 70% |