

**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 Children  Under 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% |