Lewis County Hospital District #1
Arbor Health
Po Box 1138
Morton, WA 98356

CHARITY CARE/FINANCIAL ASSISTANCE APPLICATION FORM (Confidential)

It is the policy of Lewis County Hospital District No. 1, doing business as Arbor Health Morton Hospital and Clinics, to provide essential services regardless of your ability to pay. We offer discounts based on family size and annual income. Please complete the following information and return this to our hospital, clinics or mail to: Arbor Health Morton Hospital, Po Box 1138, Morton WA 98356. Attention: Business Office

SCREENING INFORMATION

Do you need an interpreter? □ Yes □ No If Yes, list preferred language:
Has the patient applied for Medicaid? □ Yes □ No
Is the patient currently homeless? □ Yes □ No
Is the patient's medical care need related to a car accident or work injury? □ Yes □ No

PATIENT AND APPLICANT INFORMATION

Name of Head of Household/Guarantor:	Place of Employment

Guarantors Information

Address:	City	State	Zip	Phone

Please list spouse and dependents under age 18

List family members in your household, including yourself. "Family" includes people related by birth, marriage, or adoption, who live together. If additional space is needed, please attach to this application.

	Names	Date of Birth
Head of Household/Guarantor		
Spouse		
Dependent		
Dependent		
Dependent		
Dependent		
Dependent		

INCOME					
SOURCE	**SELF**	**SPOUSE**	**DEPENDENT**	**OTHER**	**Total**
Gross wages, salaries, tips etc.					
Income from business, self-employment and dependents					
Unemployment compensation, workers compensation, social security, supplemental security income, public assistance, veteran's payments, survivor benefits, pension or retirement funds					
Interest, dividends, rents, royalties, income from estates, trust, educational assistance, alimony, child support, assistance from outside the household and other miscellaneous sources.					
Total Income					

NOTE: Copies of tax returns, pay-stubs or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name (print):	
Name (signature):	
Date Signed:	

OFFICE USE ONLY
Patient Name:
Effective for date range:
Encounter Numbers:
Account Balance Prior to Discount:
Discount Amount Approved:
Balance Owing:
Approved by (if denied, patient must be notified of their appeal rights):
Date Approved:
Date Patient Notified:

VERIFICATION CHECK LIST	Yes	No
Identification/address: driver's license, utility bill, employment ID or other:		
Income: Prior year tax return, their most recent pay-stubs or other:		
Insurance cards/coverage verified:		

Arbor Health