ASTRIA SUNNYSIDE HOSPITAL

FINANCIAL ASSISTANCE PROGRAM

This application does not cover services provided by the Emergency Physician Group, Anesthesiology, Pathology and Physicians that are not employed by Astria Sunnyside Hospital.

To ensure access to health care services provided by Astria Sunnyside Hospital, a Financial Assistance Program is provided for eligible patients who are otherwise unable to pay for these services. If approved this application is good for a one time grant. Financial Assistance will cover accounts up to 180 days from date of service/discharge.

Financial Assistance Program eligibility is based on Federal Poverty Income Guidelines, and financial ability to pay as determined through an application process. Elective procedures do not qualify for the Financial Assistance Program.

The following documents must be included with your completed application:

- ☑
- ☐ *Documentation of income for 3 months – current pay stubs*
- ☐ *Completed Financial Statement - attached*
- ☐ *Tax Return – Including ALL pages and ALL Applicable W-2's*
- ☐ *All documentation regarding unemployment and/or workers compensation, alimony, child support, WIC, Food stamps and/or other financial support.*
- ☐ *Copy of the last 3 months bank statements.*
- ☐ *Mortgage or rent and/or utility verification*
- ☐ *Letter of Denial from Washington Public Assistance Program*

  If you would like enrollment assistance please contact our Hospital Navigator at 509-837-1591

- ☐ ***Sign and date the completed application***

If you have any questions or need assistance in completing this application, please contact a Financial Counselor at 509-837-1554 or by email Financial_Counselors@astria.health

A written determination of your eligibility will be provided within 30 days of receipt of the completed application with all necessary supporting documentation.

Additional Information:

_____
_____
_____
_____
_____
_____
_____

ASTRIA SUNNYSIDE HOSPITAL

FINANCIAL ASSISTANCE APPLICATION

Applicant (Guarantor) Information:

Name: _____

Address: _____

City/State/ZIP: _____

Phone Number: _____ *Social Security Number* _____-____-_____

Account(s) for which assistance is being requested:

Date of Service	*Account #*	*Patient Name*	*Amount*
		TOTAL	

Have you filed taxes, or were you claimed as a dependent in the past 2 years?
If so, attach a copy of all pages of the return with all W2s or 1099s. ☐ Yes ☐ No

Do you or anyone in the household run a small business, farm, or ranch?
If so, attach income statements and balance sheets for the previous 3 months. ☐ Yes ☐ No

Household Size: (must be able to provide legal proof of member in household: i.e. tax return, court documents, marriage license, etc.)

#	Name	Relationship to Applicant	Date of Birth	Income Source

_____ Total number in household

Household Income: (ALL household income must be reported)

Type	Monthly Amount	Annual Amount
Applicant Gross Wages		
Spouse Gross Wages		
Social Security		
Pension/VA/Railroad Retirement		
Workers Compensation		
Unemployment		
Child Support/Alimony		
Investments Income		
Other:		
Total:		

Expenses

Type	Monthly Amount	Annual Amount
Rent/Mortgage Payment		
Utilities		
Groceries		
Insurance		
Clothing		
Auto - Gas/Oil/Repairs		
Medical/Dental		
Other:		
Other:		
Total:		

ASTRIA SUNNYSIDE HOSPITAL

Assets

Cash on hand:	
Bank Name:	
Checking Account number:	
Savings Account number:	
Cash Value of Life Insurance:	
Home Market Value	
Other Real Estate Value	
Automobiles/RVs/ATVs:	
Other Investments:	
Personal & Other Misc.	
Total:	

Liabilities

Home Mortgage Balance:	
Other Real Estate Balance:	
Credit Card/Loan Balances:	
Medical/Dental Balances:	
Other Debt:	
Total:	

Net Worth

Total Assets:	
(minus) Total Liabilities:	
Net Worth:	

*Attach Small Business Balance Sheet when appropriate

I hereby request Astria Sunnyside Hospital provide services to me, or my family member, without charge, or at a reduced charge, as may be determined in processing this application. I represent under oath, that I am unable to pay for services requested, and that all of the information submitted is complete and accurate, and may be subject to verification and review by state, federal and other enforcement agencies as required by law. I agree to provide to Astria Sunnyside Hospital such additional information, as may be reasonably required, in order to substantiate my income, financial position, and ability to pay for services provided. I agree to release to SCH their agents, and their employees from all liability arising out of their responsible efforts to verify the information I have provided as a part of this application. I understand that my credit report may be used to verify this information. If I am entitled to any action or settlement from third party payers, I will take any action necessary or requested by Astria Sunnyside Hospital to obtain such assistance and will assign to SCH and upon receipt, will pay SCH all amounts recovered up to and the total amount of the outstanding balance on my account.

Signature: _____ Date: _____

NOTE: Application must be returned by _____ to ensure eligibility!

HOSPITAL USE ONLY

Date Application Provided Guarantor: _____ Date Application returned:_____

Assistance Eligibility Level: _____% Assistance $ applied to accounts: $ _____

Balance of accounts after Assistance – Established on Payment Plan: $_____

Approval Signature: _____ Date: _____