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

CHARITY CARE/FINANCIAL ASSISTANCE APPLICATION FORM (Confidential)

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION

Do you need an interpreter? □ Yes □ No If Yes, list preferred language:

Has the patient applied for Medicaid? □ Yes □ No (May be required to apply before being considered for financial assistance)

Does the patient receive state public services such as TANF, Basic Food, or WIC? □ 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

PLEASE NOTE

We cannot guarantee that you will qualify for financial assistance, even if you apply. If denied, you have the right to appeal our decision.

Once you send in your application, we may check all the information and may ask for additional information or proof of income. Please remit your application & attachments to the address above and to the attention of the Business Office

Within 14 calendar days after we receive your completed application and documentation, we will notify you of our final decision.

PATIENT AND APPLICANT INFORMATION

Last Name: First Name MI

□ Male □ Female □ Other (may specify)

Patient's Birth Date Social Security Number:

Person Responsible for Paying

Relationship to Patient: Date of Birth:

Mailing Address

City, State, Zip

Main contact number(s) Home: Cell:

Email Address:

Employment status of person responsible for paying bill:

□ Employed (date of hire): □ Unemployed (how long unemployed:

□ Self-Employed □ Student □ Disabled □ Retired □ Other (please specify)

FAMILY INFORMATION

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

How many people live in your household?

Family Member Name	Date of Birth	Relationship to Patient	Employer or Source of Income if Older than 18	Total Gross Monthly Income (before taxes) if Older than 18

All adult family member's income must be disclosed. Sources of income include, for example:

Wages, Unemployment, Self-employment, Workers compensation, Disability, SSI, Child/spousal support, work Study program (students), Pension, Retirement account distributions or other sources of income.

INCOME INFORMATION

REMEMBER: You must include proof of income with your application.

You must provide information on your family's income. Income verification is required to determine financial assistance.

All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income. income include:

Examples of proof of income include:
- ☐ A "W-2" withholding statement; or
- ☐ Current pay stubs (3 months); or proof of other income
- ☐ Last year's income tax return, including schedules if applicable; or
- ☐ Written, signed statements from employers or others; or
- ☐ Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- ☐ Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please indicate why.

EXPENSE INFORMATION

The information below is needed to help us determine your financial need.

Monthly Household Expenses:

Rent/Mortgage:		Medical Expenses:	
Insurance Premium:		Utility Expenses:	
Other Debt/Expenses:		Child support/other:	

ASSET INFORMATION

This information may be used if your income is above 101% of the Federal Poverty Guidelines.

Checking account balance: ______ Savings account balance: ______

Do your or your family members have any of these assets?

Please check all that apply

□ Stocks □ Bonds □ 401K □ Health Savings Account(s) □ Trust(s)

□ Property (excluding primary residence) □ Own a business

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to consider, such as; a financial hardship letter from another medical facility, excessive medical expenses, seasonal or temporary income, personal loss or other.

PATIENT AGREEMENT

I understand that Arbor Health Hospital and Clinics may verify information by reviewing credit information and obtaining information from other sources, which will be used to assist in determining eligibility for financial assistance.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

Signature of Person Applying: ______ Date: ______