Columbia Basin Hospital/Columbia Basin Family Medicine
Financial Assistance Application Form – confidential

This is an application for financial assistance at Columbia Basin Hospital.
Washington State requires all hospitals to provide financial assistance to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance. You can find a copy of Columbia Basin Hospital's Financial Assistance Policy and sliding fee scales on our website at www.columbiabasinhospital.org.

What does financial assistance cover? The financial assistance covers appropriate hospital-based services provided by Columbia Basin Hospital and Columbia Basin Family Medicine depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

If you have questions or need help completing this application: Please contact the Business Office located in the Administration Building or by calling 509-717-5219. You may obtain help for any reason, including disability and language assistance.

In order for your application to be processed

- □ **Provide information about your family *and***
  Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- □ **Provide us information about you or your family's gross monthly income *and***
  (income before taxes and deductions)
- □ **Provide documentation for family income, declare assets *and***
- □ **Attach additional information if needed**
- □ **Sign and date the form**

Note: **You do not have to provide a Social Security number to apply for financial assistance**. If you do provide us with your Social Security number it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

Mail or fax completed application with all documentation to: Columbia Basin Hospital, Attn Business Services Dept. 200 Nat Washington Way, Ephrata, WA 98823. Be sure to keep a copy for yourself.

To submit your completed application in person: Columbia Basin Hospital Business Office is located in the Administration Building, 200 Nat Washington Way, Ephrata, WA 98823. Our office hours are Monday thru Friday 8:00 am – 5:00 pm.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application that includes documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly!
You may receive bills until we receive all of your information.

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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** *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.
- Once you send in your complete application, we will review the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION			
Patient first name	Patient middle name		Patient last name
□ Male □ Female □ Other (may specify _____)	Birth Date		Patient Social Security Number (optional*) **optional, but needed for more generous assistance above state law requirements*
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional*) **optional, but needed for more generous assistance above state law requirements*
Mailing Address _____ _____ City State Zip Code			Main contact number(s) ( ) _____ ( ) _____ Email Address: _____
Employment status of person responsible for paying bill □ **Employed** (date of hire: _____) □ **Unemployed** (how long unemployed:_____) □ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)			

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

FAMILY SIZE _____ *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

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

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (*please explain*_____)

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INCOME INFORMATION

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

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 attach ONE of the following documents:

- A "W-2" withholding statement and/or Current pay stubs (*3 months*)
- Last year's income tax return
- 3 most recent bank statements
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance

If you are unemployed provide ONE of the following:

- Approval/denial of eligibility for Unemployment Compensation
- Unemployment compensation benefits (if applicable)
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance

If you have no proof of income or no income, please attach an additional page with an explanation.

EXPENSE INFORMATION

We use this information to get a complete picture of your financial situation.

Monthly Household Expenses:

Rent/mortgage $_____

Insurance Premiums $_____

Other Debt/Expenses $_____ (*child support, medical expenses*)

Medical expenses $_____

Utilities $_____

ASSET INFORMATION

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

Current checking account balance
$_____

Current savings account balance
$_____

Does your family have these other 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 know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that Columbia Basin Hospital may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

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