Mid-Valley Hospital & Clinic

PO Box 793, Omak, WA 98841
(509) 861-2520
mvhealth.org

Healthcare Assistance Program Application Form Instructions

This is an application for financial assistance (also known as charity care) at Mid Valley Hospital / Mid Valley Medical Group.

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. Reference Mid Valley Hospital's Healthcare Assistance Program Policy regarding eligibility and sliding fee scale.

What does financial assistance cover? The hospital financial assistance covers appropriate hospital-based services provided by Mid Valley Hospital / Mid Valley Medical Group 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: Contact the Patient Accounts office at 509-861-2440 or 509-826-7647. You may obtain help for any reason, including disability and language assistance.

In order for your application to be processed, you must:

- □ **Provide us information about your family**
  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 your family's gross monthly income (income before taxes and deductions)**
- □ **Provide documentation for family income and declare assets**
- □ **Attach additional information if needed**
- □ **Sign and date the form**

Mail or fax completed application with all documentation to: Mid Valley Hospital, Patient Accounts Department
PO Box 793
Omak, WA 98841
Fax: 509-826-7631

To submit your completed application in person: Mid Valley Hospital, Patient Accounts Department
810 Jasmine Street
Omak, WA 98841
8:00 am – 4:30 pm Monday through Friday

Be sure to keep a copy for your records.

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, including 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 within 14 days!
You may receive bills until we receive 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**
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 application, we may check all 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 SS# (Optional) Optional, but needed for more generous assistance above state law requirements
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security# (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.*

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.
Examples of proof of income include:

- A "W-2" withholding statement; or
- Current pay stubs (*3 months*); or
- 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 attach an additional page with an explanation.

EXPENSE INFORMATION

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

Monthly Household Expenses:

Rent/mortgage $_____
Insurance Premiums $_____
Other Debt/Expenses $_____ (*child support, loans, medications, other*)
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

With respect to those assets that may be taken into consideration, Mid Valley Hospital will seek only such information regarding assets as is reasonably necessary and readily available to determine the existence, availability, and value of such assets.

1. HOSPITAL will consider assets and collect information related to such assets as required by the Centers for Medicare and Medicaid (CMS) for Medicare cost reporting. a. Such information may include reporting of assets convertible to cash and unnecessary for the patient's daily living.
2. Duplicate forms of verification will not be requested. Only one current account statement is required to verify monetary assets.
3. **If no documentation for an asset is available, a written and signed statement from the patient or guarantor is sufficient.**
4. Asset information will not be used for collection activities.

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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 Mid Valley Hospital / Mid Valley Medical Group 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

For questions on amounts billed please contact a financial advisor at (509) 861-2440 or (509) 826-7647.