Financial Assistance Application Instructions

This is an application for Financial Assistance (also known as "Charity Care") at Tri-State Memorial Hospital & Medical Campus.

Financial Assistance is available 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. The state requires all hospitals to provide Financial Assistance. Tri-State Memorial Hospital & Medical Campus utilizes the Federal Poverty Guideline.

What does Financial Assistance cover? The Tri-State Memorial Hospital & Medical Campus Financial Assistance program covers medically necessary hospital and clinic services depending on your eligibility. Financial Assistance may not cover all health care costs, such as co-payments, and services provided by other organizations.

If you have questions or need help completing this application:
Tri-State Memorial Hospital Financial Counselors are available Monday through Friday from 7:30AM to 5:00PM.

Becki	*Last name A-L*	(509)758-5511 ext 2230
Marilyn	*Last name M-Z*	(509)758-5511 ext 4530
Randi	**Any*	(509)758-5511 ext 4512

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

- Provide information about your family (family includes people related by birth, marriage, or adoption who live together)
- Provide information about your family's gross monthly income (income **before** taxes and deductions)
- Provide documentation of family income and declare assets
- **Sign** and **Date** the application
- Attach additional information (if necessary)

Note: If you 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 state "not applicable" or "N/A". Not having a Social Security Number will not exclude you from eligibility for Financial Assistance.

You may receive bills until we receive your completed application and supporting documents.

Mail completed application with all documentation to:
Tri-State Memorial Hospital & Medical Campus
ATTN: Patient Financial Counselors
1221 Highland Avenue
Clarkston, WA 99403

We will notify you of the final determination of eligibility within 14 calendar days of receiving a complete Financial Assistance application, which must include documentation of income. By submitting a Financial Assistance application, you give your consent for us to make necessary inquiries to confirm the information provided in this application.

Tri-State Memorial Hospital & Medical Campus

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Screening Information

Has the patient applied for Medicaid? ☐ Yes ☐ No **May be required to apply before being considered for Financial Assistance.*

Is the patient currently homeless? ☐ Yes ☐ No

Is the patient's medical care related to a car accident or work injury? ☐ Yes ☐ No

PLEASE NOTE

- We cannot guarantee that you will qualify for assistance, even if you apply.
- Once you send in your application, we will check all information and may ask for additional information and/or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for Financial Assistance.

Patient and Applicant Information

Patient First Name	Patient Middle Initial	Patient Last Name
Birth Date	Social Security Number	
Person Responsible for Paying Bill	Relationship to Patient	Social Security Number (optional)
Mailing Address _____ _____ City State Zip		Contact Number(s) ( )_____ ( )_____ Email Address _____

Employment status of person responsible for paying bill

☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Disabled

☐ Self-Employed ☐ Other (_____)

Family Information

List family members in your household, including yourself ("Family" includes people related by birth, marriage, or adoption who live together. **Family Size:** _____

Name	Date of Birth	Relationship to Patient	If 18 years old, Employer(s) name or source of income	Total gross monthly income (**before** deductions)

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

Wages, Unemployment, Self-employment, Worker's Compensation, Disability, Social Security, Child/Spousal Support, Grants/Scholarships, Pension, Retirement Income, Other (*please explain* _____)

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Income Information

You must provide proof of your family's income. Income verification is required to determine Financial Assistance.
All family members' income must be included. Here are examples of how to provide proof of income:

- A "W-2" withholding statement
- Current paystubs (3 months)
- Last year's income tax return
- Bank statements (3 months)
- Profit/Loss statement (if self-employed)
- Written, signed statements from employer(s)
- Approval/Denial of eligibility for Medicaid and/or state-funded medical assistance
- Approval/Denial of eligibility for unemployement compensation
- If no income, you must provide an explanation in the "**Statement of Current Financial Situation**" section below

Asset Information

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

Current checking account balance
$ _____

Current savings account balance
$ _____

Does your family have other assets? **Please check all that apply**

☐ Stocks ☐ Bonds ☐ Trusts
☐ 401K ☐ Own a business ☐ Property (excluding primary residence)
☐ Health Savings Account If **yes**, available balance $_____

Statement of Current Financial Situation

Please provide information about your current financial situation that you would like us to consider, such as financial hardship, seasonal or temporary income, or personal loss. If you have no income you must explain how you support yourself. (Use additional sheet if necessary)

Applicant Agreement

I understand that Tri-State Memorial Hospital & Medical Campus may verify information by reviewing my credit information and obtaining information from other sources to assist in determining eligibility of Financial Assistance and/or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of Financial Assistance, and I will be liable and expected to pay for all services provided.

_____ _____

Signature of Person Applying Date