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 Clinic.

**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 assistance program (HAP) covers appropriate hospital-based services provided by Mid Valley Hospital / Mid Valley Clinic depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations. We require patients to exhaust all 3rd party resources, which includes applying for Medicaid.

**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 of the determination.

**PATIENT AND APPLICANT INFORMATION**

| | | | |
|---|---|---|---|
| Patient first name | Patient middle name | | Patient last name |
| □ Male □ Female<br>□ Other (may specify _____) | Birth Date | | Patient SS# (Optional) |
| Person Responsible for Paying Bill | Relationship to Patient | Birth Date | Social Security# (Optional) |
| Mailing Address<br>_____<br>_____<br>City State Zip Code | | | Main contact number(s)<br>( ) _____<br>( ) _____<br>Email Address:<br>_____ |

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.

## 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 Clinic 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