Charity Care/Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as charity care) at WhidbeyHealth Medical Center.

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.

What does financial assistance cover? The hospital financial assistance covers appropriate hospital-based services provided by WhidbeyHealth Medical Center 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: Financial Advocate at 360.678.7656 x7601 or 360.321.7656 x7601. 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

Note: You do not have to provide a Social Security number to apply for financial assistance. 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 mark “not applicable” or “NA.”

Mail or fax completed application with all documentation to: WhidbeyHealth Medical Center 101 N. Main St., Coupeville, WA  98239. FAX: 360.678.7676. Be sure to keep a copy for yourself.

To submit your completed application in person: WhidbeyHealth Medical Center 101 N. Main St., Coupeville, WA 98239.

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 promptly! You may receive bills until we receive your information.
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.
• 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 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

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 $_______________________
- Medical expenses $_______________________
- Insurance Premiums $_______________________
- Utilities $_______________________
- Other Debt/Expenses $_______________________ (child support, loans, medications, other)

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 WhidbeyHealth Medical Center 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
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-360-678-5151

Spanish
ATENCIÓN: si habla Español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-360-678-5151.

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-360-678-5151

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-360-678-5151.

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-678-5151 번으로 전화해 주십시오.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-360-678-5151.

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-360-678-5151.

Ukrainian
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-360-678-5151.

Mon-Khmer, Cambodian
[Please note: the text for Mon-Khmer, Cambodian is not fully visible in the image.]

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-360-678-5151 まで、お電話にてご連絡ください。

Amharic
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Cushite

Arabic
-- ملاحظة إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية متوفرة لك. اتصل برقم 1-360-678-5151

Panjabi

German

Laotian

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