

PERSONAL FINANCIAL STATEMENT



NORTH VALLEY HOSPITAL
Charity Care Program

Date of Birth: Telephone Number:

Guarantor Name: Spouse's Name:

Address: Spouse's Employer:

Employer:

After receiving all of the required information we can then determine if you will qualify for a reduction on your patient responsibility.

MONTHLY INCOME

Gross Income-Self:

Gross Income-Spouse:

Number of Children under the Age Of 18

List Children living with you, or that you are legally responsible for Dates of Birth, Social Security Numbers, and full names.

Four rows of form fields for listing children, each row starting with a tilde (~) and followed by three horizontal lines for data entry.

Public Assistance

Food Stamps:

Spenddown:

We require proof of all income coming into the household such as a copy of your previous years Taxes, all W-2's, a copy of your current paystub, & a copy of your last 6 months of bank statements. If you are unable to make copies at home we will copy everything for you at no charge.

Krista Harden
Patient Financial Counselor
Phone: 509-486-3131 fax: 509-486-3116

PERSONAL ASSETS:

Funds in Credit Unions: _____

Retirement Fund, IRA, Keogh plan: _____

Money held by others or Trust accounts: _____

Business Equipment: _____

Livestock: _____

Timber or Crops: _____

Reason why assets may not be available for liquidation to pay for this balance

I understand this information is being collected to determine eligibility for the Charity Care Program. Information provided is kept confidential at all times and will not be shared with anyone other than our Patient Financial Counselor. We must have all of the required information to process the application. If you are unable to provide the mandatory information, please state why in a signed and dated letter so we can attach it to the application. If you are on Social Security you may just bring in the statement you receive at the beginning of the year. DSHS has made some recent changes that directly affect our eligibility for Charity Care Program; this may require us to wait for a denial from DSHS before we can process your application. If you have any questions or concerns during this process feel free to call 509-486-3136 and speak with our Patient Financial Counselor. The customer or guarantor will have 30 days from receiving the application to complete this form and return the information. You may apply for charity at any time before the balance owed is paid in full. If it takes you longer than 30 days to return your completed application, you will be expected to set up payment arrangements. If you qualify for a 100% reduction and you have paid towards the balance, you will receive a refund of the entire amount that you paid on that specific account. If we determine that you do not qualify for charity, you will receive a letter stating why within 15 days. There is an appeal process if you are unable to receive a reduction that will be addressed on the denial letter. Contact Krista Harden our Patient Financial Counselor to answer any questions.

Have you applied for Medicaid/DSHS: _____ If so, when? _____

I authorize Okanogan County Public Hospital District #4 North Valley Hospital to verify the information supplied on this Financial Statement and all other requested documents. The information I have provided is true and accurate.

SIGNATURES:

Self: _____ Date: _____

Spouse: _____ Date: _____