NORTH VALLEY HOSPITAL

North Valley Hospital provides hospital care regardless of ability to pay.

Help with Hospital Bills!

Financial Assistance and Charity Care

What is hospital financial assistance and charity care? Hospital financial assistance and charity care help people and families in Washington pay for hospital services. Financial assistance and charity care provide either free or reduced-price care, depending on your eligibility and income.

Who receives financial assistance and charity care?

1. To receive financial assistance and charity care your income level must be within our guidelines.
2. If your income is within our guidelines, you can get assistance even if you are insured but the insurance does not cover all the costs of your care.
3. To receive financial assistance and charity care when a work-related injury, auto accident, or similar situation takes place, all other forms of payment will have to be exhausted first.
4. Financial assistance and charity care for emergent and non-emergent services may be provided regardless of the location of residency.
5. You can receive financial assistance and charity care regardless of race, creed, color, national origin, sex, sexual orientation, or the presence of any sensory, mental, or physical disability or the use of a trained guide dog or service animal by a disabled person.

What do financial assistance and charity care cover? Financial assistance and charity care cover medically necessary hospital care, including inpatient and outpatient care.

Financial assistance and charity care do ***not*** cover transportation costs or care that is not medically necessary such as cosmetic procedures, and usually do not cover doctors' services.

How do I apply? To find out what is needed to prove you are eligible and what services will be covered, please contact:

Patient Financial Counselor's
203 South Western Ave
Tonasket, WA 98855
A-L: 509-486-3136
M-Z (Bilingual): 509-486-3189

NORTH VALLEY HOSPITAL DISTRICT

Charity Care/Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as charity care) at North Valley Hospital (NVH).

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.

1. The full amount of the hospital charges will be determined to be charity care for a patient whose gross family income is at or below 200% of the current federal poverty level (consistent with WAC 246-435).
2. The following sliding fee schedule shall be used to determine the amount that shall be written off for patients with incomes between 201% and 300% of the current federal poverty level.

What does financial assistance cover? The hospital financial assistance covers appropriate hospital-based services provided by North Valley Hospital 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: Please feel free to call our Financial Counseling office at: Last name A-L (509) 486-3136 or M-Z (Bilingual) (509)-486-3189. We are located at 203 South Western Avenue, Tonasket, WA 98855. Our business hours are: Last name A-L, Monday thru Thursday, 8am-4:30pm and M-Z (Bilingual), Monday thru Friday, 8am-4:30pm. 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: North Valley Hospital at 203 South Western Avenue, Tonasket, WA 98855. Fax: (509) 486-3116: **Attention Financial Counseling. Be sure to keep a copy for yourself.**

To submit your completed application in person: Admitting at 203 South Western Avenue, Tonasket, WA 98855

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.

NORTH VALLEY HOSPITAL DISTRICT

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
					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*_____*)*

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 North Valley Hospital 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