Willapa Harbor Hospital
Working together for a healthier community

Pacific County Hospital District No. 2

FAMILY ASSISTANCE APPLICATION

Willapa Harbor Hospital understands that the cost of Health Care is a major burden even for those that have some type of health insurance.

If you have incurred a bill at Willapa Harbor Hospital and would like to apply for our financial assistance program, please fill out the attached application completely. This includes the name of your employer, the gross monthly income for you and your spouse (if any). Please include a copy of your latest pay stub and/or your latest tax return. The financial statement is very important in assessing whether your income is sufficient to meet your monthly obligations (liabilities).

While we are anxious to assist you, we may require that you apply for Washington Apple Health (DSHS).

If you need help applying for health insurance through the Health Plan Finder there are Enrollment Specialist available to help you.

- Wednesdays at Valley View Health Center in Raymond – ph # 360-942-3040
- Tuesdays and Thursdays at the Olympic Area Agency on Aging, 430 - 3rd St., Raymond ph # 360-942-2177

Please do not return your application to the business office without all of the following information attached:

1. **Application filled out completely**
2. **Income verification (paystubs or income tax information)**
3. **If you have No Insurance - a WA Apple Health Denial/Rejection Letter**

We will be unable to process your application without ALL the required information.

To Apply for Medical Insurance Online
Go to: www.wahealthplanfinder.org
Or Call: 1-855-923-4633

P. O. Box 438 • South Bend, Washington 98586 • Phone (360) 875-5526 • FAX (360) 875-6336

WILLAPA HARBOR HOSPITAL

FAMILY ASSISTANCE APPLICATION

Patient's Name: ______________________ Date of Birth: __________
Address: ______________________
Occupation of Responsible Party: ______________________
Gross Monthly Income – Current: __________ Income for past 12 months: __________
If Unemployed –Date last worked: __________ -Date Last Paid: __________

Spouse's Name: ______________________ Date of Birth: __________
Spouse's Occupation: __________ Employer: __________
Gross Monthly Income – Current: __________ Income for past 12 months: __________
If Unemployed –Date last worked: __________ -Date Last Paid: __________

An WA Apple Health *rejection letter* must be included with your application if you have no other insurance.

PLEASE INCLUDE VERIFICATION FOR ALL INCOME

List names & ages of all family members/dependents as reported on tax return (Include Yourself):

____

____

___ You are seeking financial assistance for services **already rendered** by the hospital.
___ You are seeking **Eligibility Determination** of financial assistance for services **yet** to be rendered.
Type of Service: ______________________

YOUR FINANCIAL STATEMENT:

ASSETS:

Cash on Hand: $__________
Cash in Banks/Credit Unions, etc.: $__________
Automobiles, Make & Year: __________

____

Home Purchase Price: $__________
Present Value of Home: $__________
Other Real Estate: $__________
Stocks & Bonds: $__________
Other Assets: $__________

LIABILITIES:

Rent Paid: $__________/month
Paid to Whom? __________
Own Your Home? ___Yes ___No
If yes, Mortgage pmnts: $__________
Insurance Premiums (Auto, Home, Medical, etc): $__________

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Auto Loans: $__________
Other Loans: $__________
Credit Card Balances: $__________

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-Monthly Pmnts: $__________
Owed to Doctors: $__________
Owed to Clinics: $__________
To Hospitals: $__________

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I understand that the information that I am submitting is subject to verification by Willapa Harbor Hospital and subject to review by Federal &/or State enforcement agencies and others as required. I certify that the above information is true and correct.

______________________ ______________________

Signature of Person making request **Date of application**
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3/1/2016

Willapa Harbor Hospital

< 150% Poverty Guidelines (free care)

2016

PAYMENT SCHEDUL 150-250% = sliding scale reduction

CHARITY CARE ELIGIBLE PATIENTS

Maximum amount patient would be required to pay based on gross monthly income and number of family members: 150% poverty income for family of 4 = $36,456

Patient to pay lower of	$ 990	$ 2,400	$ 4,000	$ 5,900	$ 8,700	
OR % of total bill	20%	40%	60%	75%	90%	100%

FAMILY GROSS MONTHLY INCOME

SIZE OF FAMILY						
1. Less than $1,485	$ 1,486 - $ 1,683	$1,684 - $1,881	$1,882 - $2,079	$ 2,080 - $2,277	$2,278 - $2,475	$2,476 -over
2. Less than $2,003	$ 2,004 - $ 2,270	$2,271 - $2,537	$2,538 - $2,804	$ 2,805 - $3,071	$3,072 - $3,338	$3,339 -over
3. Less than $2,520	$ 2,521 - $ 2,856	$2,857 - $3,192	$3,193 - $3,528	$ 3,529 - $3,864	$3,865 - $4,200	$4,201 -over
4. Less than $3,038	$ 3,039 - $ 3,443	$3,444 - $3,848	$3,849 - $4,253	$ 4,254 - $4,658	$4,659 - $5,063	$5,064 -over
5. Less than $3,555	$ 3,556 - $ 4,029	$4,030 - $4,503	$4,504 - $4,977	$ 4,978 - $5,451	$5,452 - $5,925	$5,926 -over
6. Less than $4,073	$ 4,074 - $ 4,616	$4,617 - $5,159	$5,160 - $5,702	$ 5,703 - $6,245	$6,246 - $6,788	$6,789 -over
7. Less than $4,591	$ 4,592 - $ 5,203	$5,204 - $5,816	$5,817 - $6,428	$ 6,429 - $7,040	$7,041 - $7,652	$7,653 -over
8. Less than $5,111	$ 5,112 - $ 5,793	$5,794 - $6,474	$6,475 - $7,156	$ 7,157 - $7,837	$7,838 - $8,519	$8,520 -over

Based on 2016 Federal Poverty Guideline
(Revised 02/02/16)

Example: Family with four dependents and total gross earnings of $3,700/month

A. Hospital bill - $8,000 : Family pays $2,400.00
(Lower of $8,000 X 40% = $3,200 **OR** $2,400) Any bill over $6,000 would pay only $2,400 maximum

B. Hospital bill - $1,000 : Family pays $400
(Lower of $1,000 X 40% = $400 OR $2,400)

Example: Family with three dependents and total gross earnings of $2,520/month
Hospital bill - balance adjusted off