Willapa Harbor Hospital
Working together for a healthier community
Pacific County Hospital District No. 2

# *Willapa Harbor Hospital*
## Financial Assistance Application Form Instructions

This is an application for financial assistance at Willapa Harbor Hospital.

**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. Eligibility Criteria

Financial Assistance is secondary to all other financial resources available to the patient, including all other third party payment sources. The guidelines used as criteria will include but not be limited to the following.

1. Persons eligible for Financial Assistance/Sliding Fee Scale will be comprised of those deemed to have undue financial hardships, considering income, resources, and obligations as determined by the hospital that make them unable to pay for all or a portion of their medical care. Such considerations will include a review of gross income and family size, and may also include other pertinent factors peculiar to each financial assistance request; such as net worth (including short and long term debts and liabilities) for those above 100% of the current federal poverty guidelines.
2. The full amount of hospital charges will be determined to be the basis for financial Assistance/Sliding Fee Scale for any patient whose gross family income is at or below 150% of the current federal poverty guidelines.
3. The following sliding fee schedule shall be used to determine the amount which shall be written off for patients with income levels between 151% and 250% of the current federal poverty level:

151% -- 170% Eighty percent (80%) Financial Assistance/Sliding Fee Scale patient max $ 990.00

171% -- 190% Sixty percent (60%) Financial Assistance/Sliding Fee Scale patient max $2,400.00

191% --210% Forty percent (40%) Financial Assistance/Sliding Fee Scale patient max $4,000.00

211% -- 230% Twenty Five percent (25%) Financial Assistance/Sliding Fee Scale patient max $5,900.00

231% -- 250% Ten percent (10%) Financial Assistance/Sliding Fee Scale patient max $8,700.00

The responsible party's financial obligation which remains after the application of the sliding fee schedule may be payable in monthly installments over a reasonable period of time, without interest or late fees, as negotiated between the hospital and the responsible party.

4. Applicants residing in a nursing home, long term care facility, or custodial care facility with a disposable income of less than $150 per month may qualify for Financial Assistance/Sliding Fee Scale even if their income exceeds the guideline limit but is used for their principal care.
5. Prima Facie Write offs: The hospital may choose to grant financial Assistance/Sliding Fee Scale based solely on the initial determination. In such cases, the hospital will not complete full verification or documentation of any request.
6. Catastrophic Financial Assistance: The hospital may write off as Financial Assistance amounts for patients with family incomes in excess of the sliding fee schedule, or may provide a higher percentage adjustment within an income category when circumstances and/or large balance amount indicate severe financial hardship or personal loss.

7. Financial assistance may cover necessary or emergency medical treatment, received in the hospital inpatient or outpatient setting. Services not qualifying under financial assistance may include transportation cost, elective procedures, or separately billed professional services provided by the hospital's medical staff. Non-residents of Washington State are eligible for Financial Assistance consistent with WAC 246-453-060, which includes emergent, non-scheduled services only.

**What does financial assistance cover?** The hospital financial assistance covers appropriate hospital-based services provided by Willapa Harbor Hospital and Pacific Family Health 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:** Willapa Harbor Hospital Business Office, 360-875-4503, 800 Alder Street South Bend, WA. 98586. 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:** Willapa Harbor Hospital, PO Box 438 South Bend, WA 98586, or fax to 360-875-6167. Be sure to keep a copy for yourself.

**To submit your completed application in person:** Business Office, 800 Alder Street, 8:00 – 4:30, 360-875-4503.

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.**

# *Willapa Harbor Hospital*

## 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<br>□ Other (may specify _____) | Birth Date | | Patient Social Security Number (optional*)<br>**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*)<br>**optional, but needed for more generous assistance above state law requirements* |
| 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* _____)

*Willapa Harbor Hospital*

# Financial Assistance Application Form – confidential

## 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 (*minimum necessary, no more than 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 Willapa Harbor 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

5/23/2018

**Willapa Harbor Hospital**

**2018**

< 150% Poverty Guidelines (free care)

PAYMENT SCHEDULE 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 = $37,650

| | | | | | | |
|---|---|---|---|---|---|---|
| **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 $ 1,517 | $ 1,518 - $1,720 | $1,721 - $ 1,922 | $1,923 - $ 2,124 | $ 2,125 - $2,327 | $2,328 - $ 2,529 | $ 2,530 -over |
| 2. Less than $ 2,057 | $ 2,058 - $2,332 | $2,333 - $ 2,606 | $2,607 - $ 2,880 | $ 2,881 - $3,155 | $3,156 - $ 3,429 | $ 3,430 -over |
| 3. Less than $ 2,597 | $ 2,598 - $2,944 | $2,945 - $ 3,290 | $3,291 - $ 3,636 | $ 3,637 - $3,983 | $3,984 - $ 4,329 | $ 4,330 -over |
| 4. Less than $ 3,137 | $ 3,138 - $3,556 | $3,557 - $ 3,974 | $3,975 - $ 4,392 | $ 4,393 - $4,811 | $4,812 - $ 5,229 | $ 5,230 -over |
| 5. Less than $ 3,677 | $ 3,678 - $4,168 | $4,169 - $ 4,658 | $4,659 - $ 5,148 | $ 5,149 - $5,639 | $5,640 - $ 6,129 | $ 6,130 -over |
| 6. Less than $ 4,217 | $ 4,218 - $4,780 | $4,781 - $ 5,342 | $5,343 - $ 5,904 | $ 5,905 - $6,467 | $6,468 - $ 7,029 | $ 7,030 -over |
| 7. Less than $ 4,757 | $ 4,758 - $5,392 | $5,393 - $ 6,026 | $6,027 - $ 6,660 | $ 6,661 - $7,295 | $7,296 - $ 7,929 | $ 7,930 -over |
| 8. Less than $ 5,297 | $ 5,298 - $6,004 | $6,005 - $ 6,710 | $6,711 - $ 7,416 | $ 7,417 - $8,123 | $8,124 - $ 8,829 | $ 8,830 -over |

Based on 2018 Federal Poverty Guideline

(Revised 05/23/2018)

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