



Financial Assistance Application Form Instructions

This is an application for financial assistance at Klickitat Valley Health.

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. The hospital policy regarding eligibility and sliding scale are available upon request.

What does financial assistance cover? The hospital financial assistance covers appropriate hospital-based services provided by Klickitat Valley Health and KVH Family Medicine 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 contact Patient Financial Services @ 509-772-2838 or 509-773-1015

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 completed application with all documentation to: Klickitat Valley Health at 310 S Roosevelt, Goldendale, WA 98620, ATTN: Patient Financial Services. Be sure to keep a copy for yourself.

To submit your completed application in person: To Patient Financial Services at Klickitat Valley Health, 310 S Roosevelt, Goldendale, WA 98620

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.**

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 (*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.

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 Klickitat Valley Health 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