KLICKITAT VALLEY HEALTH
Caring for our Community

Application for Financial Assistance

Klickitat Valley Health encourages you to apply for Financial Assistance if you are low income and need help paying medical bills. Financial Assistance may offer either free care or reduced-price care based on your eligibility and income. If you have question or need help completing this application, please call **Tammy** (509-773-1015) or **Christine** (509-773-1062).

Please print

Personal Information

Patient's Name: _____

If patient is a minor or a dependent, print name of parent or other responsible party:

_____

Mailing Address:

_____

_____

Telephone Number: Work ( ) _____ Home ( ) _____

Number of people in family (living in tax household): _____

Health Insurance Information

Print name of Medical Insurance Company: _____

Policy Number / Group Number: _____

Other Coverage? Yes No Please identify other coverage: Medicare Medicaid

_____

Is the medical treatment because of a car accident or other third party injury? Yes No

Is the medical treatment because of an on-the-job injury or accident? Yes No

Income

Be sure to include with your application documents that give the income amounts you list below. For example:

- Pay stubs from all employment for three month period
- A "W-2" withholding statement
- Last year's income tax return
- Letter from Social Security Administration

Current family monthly income (before taxes are taken out): $_____

Total family income for the past three months (before taxes are taken out): $_____

Has your family had any seasonal or temporary increases or decreases in income? Or, do you expect your income to change in the next three months?

Yes___ No___ If yes, please describe:

_____

_____

Have you recently suffered severe financial hardship or personal loss (for example, other medical expenses, death of a loved one, loss of job or wages, loss of home, auto, or other property)?

Yes___ No___ If yes, please explain:

_____

_____

Do the documents that you are including with this application show your current financial situation correctly?

Yes___ No___ If no, why not?

_____

_____

If you are asking for Financial Assistance for services already provided by Klickitat Valley Health, please list date of service and what services you received.

_____

_____

From the Federal Register dated February, 2017 Federal Poverty Guidelines for all states except Alaska and Hawaii and The District of Columbia:

Percent of Poverty Level

GROSS YEARLY INCOME

FAMILY SIZE	100%	150%	200%	300%
1	$12,060.00	$18,090.00	$24,120.00	$36,180.00
2	$16,240.00	$24,360.00	$32,480.00	$48,720.00
3	$20,420.00	$30,630.00	$40,840.00	$61,260.00
4	$24,600.00	$36,900.00	$49,200.00	$73,800.00
5	$28,780.00	$43,170.00	$57,560.00	$86,340.00
6	$32,960.00	$49,440.00	$65,920.00	$98,880.00
EACH ADDL PERSON ADD	$4,180.00	$6,270.00	$8,360.00	$12,540.00

>100% get all charges written off & refund of payments once approved for Financial Assistance
100% to 150% get all charges written off once approved for Charity Care
150% to 200% get 100% of RCC = Current (31%) Discount
200% to 300% get 130% of RCC = Current (10%) Discount
<300% get 0% of RCC = Current (0%) Discount

Please note that any account that has been designated bad debt and has been turned over to a collection agency and is now in legal does not qualify for Financial Assistance. Some services will not qualify as emergent care such as physical therapy, occupational therapy, and extended care stays. Those are only a few examples of non-emergent care.

I understand that the information I am giving will be verified by Klickitat Valley Health and reviewed by state and/or federal enforcement agencies and others as required. I certify that the above information is true and accurate to the best of my knowledge.

Applicant's Signature_____Date_____

Mail this application with all documentation within 14 days of receipt of application to:

Klickitat Valley Health
Attn: Tammy or Christine
310 S Roosevelt Ave
Goldendale, WA 98620