



# FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

This is an application for Financial Assistance (also known as “Charity Care”) at Tri-State Memorial Hospital & Medical Campus.

Financial Assistance is available 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 state requires all hospitals to provide Financial Assistance. Tri-State Memorial Hospital & Medical Campus utilizes the Federal Poverty Guideline.

## What does Financial Assistance cover?

The Tri-State Memorial Hospital & Medical Campus Financial Assistance program covers medically necessary hospital and clinic services depending on your eligibility. Financial Assistance may not cover all health care costs, such as co-payments, and services provided by other organizations.

## If you have questions or need help completing this application:

Tri-State Memorial Hospital Financial Counselors are available Monday through Friday from 7:30AM to 5:00PM.

Raven	Last Name A-L	509.758.5511 ext. 2230
Janet	Last Name M-Z	509.758.5511 ext. 2231

## In order for your application to be processed, you must:

- Provide information about your family (family includes people related by birth, marriage, or adoption who live together)
- Provide information about your family’s gross monthly income (before taxes and deductions)
- Provide documentation of family income and declare assets
- Sign and date the application
- Attach additional information (if necessary)

*Note: If you provide us with your Social Security Number, it will help speed up the processing of your application. Social Security Numbers are used to verify the information provided to us. If you do not have a Social Security Number, please state “not applicable” or “N/A.” Not having a Social Security Number will not exclude you from eligibility for Financial Assistance.*

**You may receive bills until we receive your completed application and supporting documents.**

## Mail completed application with all documentation to:

Tri-State Memorial Hospital & Medical Campus  
ATTN: Patient Financial Counselors  
1221 Highland Avenue  
Clarkston, WA 99403

We will notify you of the final determination of eligibility within 14 calendar days of receiving a complete Financial Assistance Application, which must include documentation of income. By submitting a Financial Assistance Application, you give your consent for us to make necessary inquiries to confirm the information provided in this application.



**Note:**

- We cannot guarantee that you will qualify for assistance, even if you apply
- Once you send in your application, we will check all information and may ask for additional information and/or proof of income

**Screening Information**

Has the patient applied for Medicaid?     Yes     No    (may be required to apply before being considered for Financial Assistance)  
 Is the patient currently homeless?     Yes     No  
 Is the patient's medical care related to a car accident or work injury?     Yes     No

**Patient and Applicant Information**

Patient Name (first, middle, last) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Social Security # (optional) \_\_\_\_\_ Email \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone # \_\_\_\_\_ Phone Type \_\_\_\_\_ Alt Phone # \_\_\_\_\_ Phone Type \_\_\_\_\_  
 Person Responsible for Paying Bill \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Social Security # (optional) \_\_\_\_\_ Phone # \_\_\_\_\_ Phone Type \_\_\_\_\_  
 Employment status of person responsible for paying bill    Employed    Unemployed    Retired    Student    Disabled  
 Self-employed    Other \_\_\_\_\_

**Applicant Family Information**

List family members in your household, including yourself ("Family" includes people related by birth, marriage, or adoption who live together)

Family Size \_\_\_\_\_

Name	Date of Birth	Relationship to Patient	If 18 Years Old, Employer(s) Name or Source Of Income	Total Gross Monthly Income (before deductions)

**All family members' income must be disclosed.**

Sources of income include: Wages, Unemployment, Self-employment, Worker's Compensation, Disability, Social Security, Child/Spousal Support, Grants/Scholarships, Pension, Retirement Income, Other, please explain \_\_\_\_\_



## Screening Information

**You must provide proof of your family's and your income.** All family members' income must be included. Income verification is required to determine Financial Assistance. Some examples of how to provide proof of income are:

- "W-2" withholding statement
- Current pay stubs (3 months)
- Last year's income tax return
- Bank statements (3 months)
- Profit/loss statement (if self-employed)
- Written, signed statements from employer(s)
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance
- Approval/denial of eligibility for unemployment compensation

**If no income, you must provide an explanation in the "Statement of Current Financial Situation" section below.**

## Applicant Asset Information

*This information may be used if your income is above 200% of Federal Poverty Guidelines.*

Current checking account balance \$ \_\_\_\_\_ Current savings account balance \$ \_\_\_\_\_

Do you or your family have other assets? Check all that apply  Own a business  Stocks  Bonds  Retired  Trusts  
 401K  Property (excluding primary residence)  Health Savings Account If yes, available balance \$ \_\_\_\_\_

## Statement of Current Financial Situation

Please provide information about your current financial situation that you would like us to consider, such as financial hardship, seasonal or temporary income, or personal loss. If you have no income you must explain how you support yourself (use additional sheet if necessary).

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## Applicant Agreement

I understand that Tri-State Memorial Hospital & Medical Campus may verify information by reviewing my credit information and obtaining information from other sources to assist in determining eligibility of Financial Assistance and/or payment plans.

I understand that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of Financial Assistance, and I will be liable and expected to pay for all services provided.

\_\_\_\_\_  
Applicant Signature

Date \_\_\_\_/\_\_\_\_/\_\_\_\_