TriState Health

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

This is an application for Financial Assistance (also known as “Charity Care”) at TriState Health.

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. TriState Health utilizes the Federal Poverty Guideline.

What does Financial Assistance cover?
The TriState Health 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:
TriState Financial Counselors are available Monday through Friday from 8:00AM to 5:00PM Pacific Standard Time by calling 509.758.4652, option 2.

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:

TriState Health
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.

Idaho Medicaid Contact Information
877.456.1233
(Opt. 1 for English, Opt. 5 for new benefits)

Washington Medicaid Contact Information
800.562.3022

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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

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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 TriState Health 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.

_____ Date ____/____/_____

Applicant Signature