Charity Care/Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as charity care) at Kadlec Regional Medical Center.

Federal and state law 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. To view our financial assistance policy and slide scale guidelines, please go to the hospital website from www.kadlec.org and click on Pay Bill and Financial Assistance.

What does financial assistance cover? The medical financial assistance covers appropriate hospital services medically necessary hospital care provided by our hospital 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: Our financial assistance policies, information about the programs, and the application materials are available on our website or via phone. You may obtain help for any reason, including disability and language assistance. Translated written documents available upon request. Here’s how to contact us: www.kadlec.org and click on Pay Bill and Financial Assistance.

Customer Service Representatives at: 855-367-1343 or 509-942-2626

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) to include pay stubs, W-2 forms, tax returns, social security awards letters, etc (see financial assistance application Income Section for more examples)

□ Provide documentation for family income and declare assets

□ Attach additional information if needed

□ Sign and date the financial assistance 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: Kadlec Regional Medical Center, Attn: Patient Financial Services, 888 Swift Boulevard, Richland, WA 99352. Be sure to keep a copy for yourself.

To submit your completed application in person: Submit directly to Billing Representative at 1268 Lee Blvd between 8:15am – 4:30pm Monday through Friday.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 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.
**Charity Care/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

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Do you need an interpreter?</td>
<td></td>
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<tr>
<td>Has the patient applied for Medicaid?</td>
<td></td>
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<tr>
<td>Does the patient receive state public services such as TANF, Basic Food, or WIC?</td>
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<tr>
<td>Is the patient currently homeless?</td>
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<tr>
<td>Is the patient’s medical care need related to a car accident or work injury?</td>
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### 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 days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

### PATIENT AND APPLICANT INFORMATION

<table>
<thead>
<tr>
<th>Patient first name</th>
<th>Patient middle name</th>
<th>Patient last name</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Male □ Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other (may specify ____________)</td>
<td>Birth Date</td>
<td>Patient Social Security Number (optional*)</td>
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<td></td>
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<td>*optional, but needed for more generous assistance above state law requirements</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Person Responsible for Paying Bill</th>
<th>Relationship to Patient</th>
<th>Birth Date</th>
<th>Social Security Number (optional*)</th>
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<td>*optional, but needed for more generous assistance above state law requirements</td>
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<tr>
<th>Mailing Address</th>
<th>Main contact number(s)</th>
<th>Email Address:</th>
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</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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</thead>
</table>

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 ___________**

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Relationship to Patient</th>
<th>If 18 years old or older: Employer(s) name or source of income</th>
<th>If 18 years old or older: Total gross monthly income (before taxes):</th>
<th>Also applying for financial assistance?</th>
</tr>
</thead>
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<td>Yes / No</td>
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<td>Yes / No</td>
</tr>
</tbody>
</table>

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_______________*)
**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.

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**EXPENSE INFORMATION**

*We use this information to get a more complete picture of your financial situation.*

**Monthly Household Expenses:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Rent/mortgage</td>
<td>$______________</td>
</tr>
<tr>
<td>Insurance Premiums</td>
<td>$______________</td>
</tr>
<tr>
<td>Other Debt/Expenses</td>
<td>$______________</td>
</tr>
</tbody>
</table>

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**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

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**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.

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**PATIENT AGREEMENT**

I understand that Kadlec Regional Medical Center 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: ___________________________