



Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as “charity care”).

Samaritan Healthcare is committed to ensuring our patients get the care they need regardless of ability to pay for that care. Providing health care to those who cannot afford to pay is part of our mission and state law requires hospitals to provide free and discounted care to eligible patients. You may qualify for free or discounted care based on family size and income, **even if you have health insurance.**

What does financial assistance cover? Appropriate and medically necessary hospital and clinic-based medical services provided by Samaritan Healthcare. Eligibility is based upon information provided by you in the form of a Financial Assistance Application and supporting income documentation. Income criteria, based on Federal Poverty Level, will be used to determine eligibility for free or discounted care. 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 at (509) 793-9715. You may obtain help for any reason, including disability and language assistance. Translated versions of the application form is available upon request in Spanish and Russian.

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

- **Provide us information about your family.**
 - Complete the Family Information section below, including Family Size. Family is defined as “*people related by birth, marriage, or adoption who live together.*”
- **Provide us information about your household gross monthly income** (income before taxes and deductions).
- **Provide supporting documentation for all household income.**
 - Examples of acceptable income verification documents listed below.
- **Sign and date the form,** acknowledging that the information provided is true and correct to the best of your knowledge.

Note: You do not have to provide a Social Security number to apply for financial assistance. If you do not have a Social Security number, please write “not applicable” or “N/A”.

Mail, Fax, or Email your application with all supporting income documentation to Samaritan Healthcare; ATTN: Patient Financial Services, 660 S. Coolidge Street, Moses Lake, WA 98837, Fax to (509) 764-3244, or Email FinancialCounselor@SamaritanHealthcare.com.

To receive in-person assistance, Patient Financial Services is located at 1616 S. Pioneer Way, Moses Lake, WA 98837. We are open Monday through Friday, 8:00 AM to 5:00 PM.

We will notify you of the final determination of eligibility within 14 calendar days of receiving a completed financial assistance application, which must include the required supporting documentation.

We want to help! Please submit your application promptly and ensure all supporting income documentation is included. You may receive bills until that time.

Financial Assistance Application Form – confidential (page 2)

INCOME INFORMATION

REMEMBER: All family members' income must be disclosed. Provide proof for every identified source of income.

Source of income includes, for example:

-Wages -Unemployment -Self-Employment -Worker's Compensation -Disability -SSI -Child/Spousal Support
-Pension -TANF/Basic Food -Retirement Distribution -Rental Income -Other (please explain): _____

Supporting Documentation (i.e., "proof of income") includes, for example:

- A "W-2" withholding statement for current year
- Current pay stubs from all employment (3 months)
- An income tax return from the most recent calendar year, including schedules (if applicable)
- Current bank statement reflecting deposit(s) for all other sources of income (3 months)
- PFMLA (Paid Family Medical Leave of Absence) deposit notification or payment statement
- Social Security Benefit award letter, Veteran Benefit award letter, Workers Compensation (L&I) award letter
- Forms approving or denying eligibility for Medicaid and/or state-funded medical assistance
- Forms approving or denying unemployment compensation
- Written statements from DSHS or other State Agency
- Retirement, Pension or Annuity Payment award letter
- Self-employment income tax forms, including schedules with Profit & Loss statement
- Samaritan Healthcare Employment Verification Form

If you have no income, you may submit a written and signed attestation explaining your circumstances.

MONTHLY HOUSEHOLD EXPENSE INFORMATION

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

Rent/Mortgage	\$ _____	Other Debt/Expenses	_____
Medical or Prescription	\$ _____	Other Debt/Expenses	\$ _____
Medical Insurance Premium(s)	\$ _____	Other Debt/Expenses	_____
Utilities	\$ _____	Other Debt/Expenses	\$ _____

ADDITIONAL INFORMATION

Please attach additional page(s) if there is other information about your current financial circumstances that you would like us to know, such as; a significant financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that Samaritan Healthcare may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I have given 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(s) Applying

Date

Mail, Fax, or Email your application with all supporting documentation to:

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