NEWPORT HOSPITAL & HEALTH SERVICES

Financial Assistance Application Form Instructions

This is an application for financial assistance at Newport Hospital & Health Services.

Washington State 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. http://newporthospitalandhealth.org/patients-families/patient-financial-services/charity-careuncompensated-services/

What does financial assistance cover? Newport Hospital & Health Services is committed to the provision of Health Care services to all persons in need of medical attention, regardless of ability to pay. ***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 (509) 447-9351 or (800) 256-3727
You may obtain help for any reason, including disability and language assistance.

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)**
- ☐ **Attach additional information if needed**
- ☐ **Sign and date the 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 or fax completed application with all documentation to: Newport Hospital & Health Services, Attn: Patient Financial Services 714 W Pine St. Newport, WA 99156. Be sure to keep a copy for yourself.

To submit your completed application in person: Newport Hospital & Health Services has 2 locations you can speak with a Financial Counselor. **Newport Hospital Main Admissions, please request to speak with a financial counselor**. You can also go to the Patient Financial Services office located at: 610 W 2nd St., Newport, WA 99156, Monday through Friday 8:00 am to 4:30 pm (Excluding Holidays).

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar 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.

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Please fill out all information completely. If it does not apply, write "NA."
Please attach additional pages if needed.

SCREENING INFORMATION

Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*

Has the patient applied for Medicaid? □ **Yes** □ **No** *May be required to apply before being considered for financial assistance*

Does the patient receive state public services such as TANF, Basic Food, or WIC? □ **Yes** □ **No**

Is the patient currently homeless? □ **Yes** □ **No**

Is the patient's medical care related to a car accident or work injury? □ **Yes** □ **No**

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 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION

Patient first name	Patient middle name		Patient last name
□ Male □ Female □ Other (may specify_____________)	Birth Date		Social Security Number (optional*)
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional*)

Physical Address ____

Mailing Address____
(if different than Physical address)

City State Zip Code

Main contact number(s)
( ) ___________________
( ) ___________________
Email Address:
____

Employment status of person responsible for paying bill □ **Employed** (since_______) □ **Unemployed** (since______)
□ **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 ___________ *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	Name	Date of Birth	Relationship to Patient

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INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application.*

Please provide information on your **family's income**. Income verification is required to determine financial assistance. All adult family members' income must be disclosed. If you cannot provide documentation, you may submit a written signed statement describing your income and living situation. 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.**

Monthly Gross Income:

Gross Monthly Wages $______________ Unemployment $______________ Other $______________
Social Security Benefits $______________ Child/Spousal Support $______________
Pension/Retirement $______________ Self Employed $______________

EXPENSE INFORMATION

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

Monthly Household Expenses:

Rent/Mortgage $______________ Medical expenses $_________________________
Insurance Premiums $______________ Utilities $_________________________
Other Debt/Expenses $______________ (*child support, loans, medications, other*)

ADDITIONAL INFORMATION

Has your family experienced any seasonal or temporary decreases in your income, or do you expect your income to decrease? Have you suffered severe financial hardship or personal loss? (medical expenses, death in family)?

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PATIENT AGREEMENT

I understand that Newport Hospital & Health services 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 information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.

_________________________________ _________________________________ _________________________

Signature of Responsible Party Print name of Responsible Party Date