



Newport Hospital and Health Services

2019 PROPERTY TAX APPLICATION

I, _____, am asking that the property tax discount be applied to the attached outstanding 2019 medical expenses bill for services rendered to me or a family member. I understand that in order to qualify as a dependent, a person must be either the applicant's lawful spouse or dependent child. I further understand that the credit may be applied only to the portion of the billed charges that is not reimbursed directly or indirectly by a third party payer, that the amount of the credit is limited to the amount of the property taxes assessed for the 2019 tax year, and that *the amount of the credit* may not exceed \$500.*

I have been assessed \$_____ in property taxes for the benefit of Public Hospital District No. 1, Pend Oreille County, within the related year of 2019.

I have attached to this application a copy of appropriate evidence of the amount of 2019 property taxes paid for the benefit of the District, such as a copy of the related property tax statement from the county.

I have attached a copy of the related 2019 medical service statement that I am requesting to have the property tax credit applied to.

**Expenses are eligible only for property taxes that appear on your property tax statement (under "Voted" heading): HOSPITAL DISTRICT 1 0.5320275065
OR on the Pend Oreille County Assessor's webpage as: HOSPITAL #1 BOND 0.5320275065
Taxes paid on the HOSP1 - HOSPITAL 1 GENERAL do not qualify under the program.*

I certify under penalty of perjury that the above information is true and correct.

DATED this ____ day of _____, 20__.

Name of Patient: _____ Guarantor Name: _____

Relation to Applicant (check ONE): ___self ___lawful spouse ___dependent child

Date(s) of service: ___/___/___ (MM/DD/YYYY) ___/___/___ (MM/DD/YYYY)
___/___/___ (MM/DD/YYYY) ___/___/___ (MM/DD/YYYY)

** If you need to submit information for another dependent, please complete a separate form.*

Printed Name of Applicant _____ Signature of Applicant _____

Address _____ City, ST _____ Zip Code _____

Telephone Number where applicant can be reached: (_____) _____ - _____

** Refunds will not be issued for 2019 balances paid prior to processing this application.*