



# Newport Hospital and Health Services

## 2021 PROPERTY TAX APPLICATION

I, \_\_\_\_\_, am asking that the property tax discount be applied to the attached outstanding 2021 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 2021 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 2021.

*I have attached to this application a copy of appropriate evidence of the amount of 2021 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 2021 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 0.4757981194  
OR on the Pend Oreille County Assessor's webpage as: HOSPITAL #1 BOND 0.4757981194  
*\*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 2021 balances paid prior to processing this application.  
Form updated 2/16/2021*