Newport Hospital and Health Services

2024 PROPERTY TAX APPLICATION

I, _____, am asking that the property tax discount be applied to the attached outstanding 2024 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 2024 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 2024.

☐ ***I have attached to this application a copy of appropriate evidence of the amount of 2024 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 2024 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 0.3332401721
OR on the Pend Oreille County Assessor's webpage as: HOSPITAL #1 BOND 0.3332401721
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 2024 balances paid prior to processing this application.*
Form updated 1/10/2024

Return this form to Patient Financial Services, Newport Hospital and Health Services
714 W. Pine Street, Newport, WA 99156 • (509) 447-9351, Option 2 • www.NewportHospitalAndHealth.org