ASTRIA TOPPENISH HOSPITAL

Astria Toppenish Hospital provides hospital care regardless of ability to pay.

Help with Hospital Bills!

Financial Assistance and Charity Care

What are hospital financial assistance and charity care? Hospital financial assistance and charity care help people and families in Washington pay for hospital services. Financial assistance and charity care provide either free or reduced-price care, depending on your eligibility and income.

Who receives financial assistance and charity care?

1. To receive financial assistance and charity care your income level must be within our guidelines.

2. If your income is within our guidelines, you can get assistance even if you are insured but the insurance does not cover all the costs of your care.

3. To receive financial assistance and charity care you can*not* be involved in a work related injury or auto accident or similar situation where someone else has a legal responsibility to pay for the costs of hospital care.

4. To receive financial assistance and charity care for non-emergent services you must live within the hospital's service area.

5. You can receive financial assistance and charity care regardless of *race, creed, color, national origin, sex, sexual orientation, or the presence of any sensory, mental, or physical disability or the use of a trained dog guide or service animal by a disabled person.*

What do financial assistance and charity care cover? Financial assistance and charity care cover medically necessary hospital care, including inpatient and outpatient care.

Financial assistance and charity care do *not* cover transportation costs or care that is not medically necessary such as cosmetic procedures, and usually do not cover doctors' services.

How do I apply? To find out what is needed to prove you are eligible and what services will be covered, please contact:

Charity Care
Astria Toppenish Hospital
509-865-1690

ASTRIA TOPPENISH HOSPITAL

Charity Care/Financial Assistance Program Application

Astria Toppenish Hospital's Charity Care Policy has been approved by the Washington State Department of Health. In order to determine if you are eligible for Charity Care assistance the Hospital needs to verify you financial status. That is the purpose of this form. Please provide as much of the information and documentation requested below as you are able. A Hospital representative is available to answer your questions.

Patient Account Number_____ **Date of Application**_____

PATIENT INFORMATION

Name_____

Address_____

City_____

State/Zip_____ _____

Home Phone (____)_____

Cell Phone (____)_____

SS#_____

Employer_____

Address_____

City_____

State/Zip_____ _____

Work Phone (___)_____

Length of Employment_____

Supervisor_____

PATIENT/GUARANTOR/SPOUSE

Name_____

Address_____

City _____

State/Zip_____ _____

Home Phone (____)_____

Cell Phone (____)_____

SS#_____

Employer_____

Address_____

City_____

State/Zip_____ _____

Work Phone (____)_____

Length of Employment_____

Supervisor_____

ASTRIA TOPPENISH HOSPITAL

Charity Care Application Continued

RESOURCES

Checking: Yes No

Savings: Yes No

Cash on Hand: $_____

Vehicle 1: Yr_____Make_____Model_____

Vehicle 2: Yr_____Make_____Model_____

Vehicle 3: Yr_____Make_____Model_____

INCOME

Patient /Guarantor:

Wages (Monthly)_____

Other Income:

Child Support $_____

VA Benefits $_____

Workers Comp: $_____

SSI: $_____

Other: $_____

Spouse/Second Parent:

Wages(Monthly)_____

Other Income:

Child Support $_____

VA Benefits $_____

Workers Comp: $_____

SSI: $_____

Other: $_____

LIVING ARRANGEMENTS

Rent_____ Own_____ Other (explain)_____ Number in Household_____

Landord/Mortage Holder:_____

Phone Number (_____)_____

Monthly payment $_____

ASTRIA TOPPENISH HOSPITAL

Charity Care Application Continued

REQUESTED DOCUMENTS

Please provide any one of the following documents to assist the Hospital in processing your application for Charity Care:

Documentation of Income:

(a) Last year's "W-2" withholding statement;
(b) Pay stubs for the last 4 months;
(c) An income tax return from the most recently filed calendar year;
(d) Forms approving or denying eligibility for Medicaid and/or state-funded medical assistance;
(e) Forms approving or denying unemployment compensation; or
(f) Written statements from employers or welfare agencies indicating your income.

If you are unable to provide any of the documentation described above, submit a signed written statement detailing the amount of your income for the past year and the source(s) of that income.

Certification of Applicant:

I hereby certify that the information and related documentation I am providing in connection with this application are true, complete and correct. I understand that the information provided is subject to verification by the Hospital and has been provided to determine my eligibility for Charity Care assistance. I understand that providing false information may result in the Hospital denying my application for financial assistance.

If my income is found to exceed 300% of the Federal Poverty Level Income Guidelines, I hereby grant permission to the Hospital to obtain a copy of my credit report to be used to determine my eligibility for Charity Care.

Signature of Applicant: _____ Date:_____

Hospital Representative Overseeing Charity Care Application_____

Approval/Authorization of Charity Write-Off **Amount Approved $ _____**

BOM_____CFO_____CEO_____