Othello Community Hospital

Summary of Financial Assistance/Charity Care Policy

Othello Community Hospital is committed to ensuring our patients get the hospital care they need regardless of ability to pay for that care. Providing health care to those who cannot afford to pay is part of our mission and state law requires hospitals to provide free and discounted care to eligible patients. You may qualify for free or discounted care based on family size and income, even if you have health insurance.

If you think you may have trouble paying for your health care, please talk with us. When possible, we encourage you to ask for financial help before receiving medical treatment.

What Is Covered? For emergency and other appropriate hospital-based services at Othello Community Hospital we provide free care and financial assistance/charity care to eligible patients on a sliding fee scale basis, with discounts ranging from 35 to 100%. No patient eligible for financial assistance/charity care will be charged more than amounts generally billed to patients who have insurance

How to Apply: Any patient may apply to receive financial assistance/charity care by submitting an application and providing supporting documentation. If you have questions, need help, or would like to receive an application form or more information, please contact us:

- When you are checking in or checking out of the hospital;
- By telephone: If last name starts with A-Garza, M contact Jeri at (509) 331-2665; Garza, N-Mon contact Diana at (509) 331-2661; Moo-Z contact Erika at (509) 331-2656.
- In person: Othello Community Hospital's Business Office located on main level of Hospital
- Can also contact Othello Community Hospital's Business office To obtain documents via mail free of charge

If English is Not Your First Language: Translated versions of the application form, financial assistance policy, and this summary, are available upon request in Spanish.

Payment plans: Any balance for amounts owed by you is due within 30 days. The balance can be paid in any of the following ways: credit card, payment plan, cash or check. If you need a payment plan, please call the number on your billing statement.

Emergency Care: Othello Community Hospital has a dedicated emergency department and provides care for emergency medical conditions (as defined by the Emergency Medical Treatment and Labor Act) without discrimination consistent with available capabilities, without regard to whether or not a patient has the ability to pay or is eligible for financial assistance.

Thank you for trusting us with your care.

Othello Community Hospital

Charity Care/Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as charity care) at The Othello Community Hospital.

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.

What does financial assistance cover? The hospital financial assistance covers appropriate hospital-based services provided by Othello Community Hospital depending upon your eligibility. 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: Contact the Business office. If your last name starts with A-Garza, M contact Jeri at (509) 331-2665;Garza,N-Mon Contact Diana at (509)331-2661;Moo-Z Contact Erika at (509)331-2656. You may obtain help for any reason, including disability and language assistance. Business Hours 8:00 am to 5:00pm Monday thru Friday.

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)**
- □ **Provide documentation for family income and declare assets**
- □ **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: Othello Community Hospital, 315 N. 14th Ave., Othello, WA, 99344. Fax Number: 509-488-3857. Business Hours 8:00 am to 5:00 pm Monday thru Friday. Be sure to keep a copy for yourself.
To submit your completed application in person: Business Office located inside the hospital on the main level

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.

We want to help. Please submit your application promptly!
You may receive bills until we receive your information.

Othello Community Hospital

Charity Care/Financial Assistance Application Form – confidential

Please fill out all information completely. If it does not apply, write "NA." 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 need 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		Patient Social Security Number
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number
Mailing Address _____ _____ City State Zip Code			Main contact number(s) ( ) _____ ( ) _____ Email Address: _____

Employment status of person responsible for paying bill

□ **Employed** (date of hire: _____) □ **Unemployed** (how long unemployed:_____)

□ **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	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (*please explain_____)*

Othello Community Hospital

Charity Care/Financial Assistance Application Form – confidential

INCOME INFORMATION

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

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. 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.

EXPENSE INFORMATION

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

Monthly Household Expenses:

Rent/mortgage $_____

Insurance Premiums $_____

Other Debt/Expenses $_____ (*child support, loans, medications, other*)

Medical expenses $_____

Utilities $_____

ASSET INFORMATION

This information may be used if your income is above 101% of the Federal Poverty Guidelines.

Current checking account balance
$_____

Current savings account balance
$_____

Does your family have these other assets?

Please check all that apply

□ Stocks □ Bonds □ 401K □ Health Savings Account(s) □ Trust(s)
□ Property (excluding primary residence) □ Own a business

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that Othello Community Hospital 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 financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

_____ _____

Signature of Person Applying Date