Financial Assistance Application

Original Effective Date: 5/20/2024 *Revision Date: 5/20/2024* *Approved by: Jason Adler*

Kittitas County Public Hospital District 2, d/b/a Upper Kittitas County Medic One ("Medic One") is committed to providing Advanced Life Support (ALS) services regardless of ability to pay. In order to fulfill this commitment, Medic One offers a Financial Assistance Program. Patients may qualify for reduced or waived charges for services based on income and family size, even if you have health insurance.

What does financial assistance cover?

Financial assistance covers appropriate emergency care services provided by Medic One Advanced Life Support (ALS) services depending upon your eligibility. Financial assistance may not cover all emergency care costs, including services provided by other organizations.

If you have questions or need help completing this application:

Please call (800) 238-9398 or email at kittitaschd2@emspatient.com. You may obtain help for any reason, including disability and language assistance.

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.
- 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. 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:

Systems Design Attn: Patient Financial Services PO Box 3510 Silverdale, WA 98383 or via fax to (360) 394-7097. Be sure to keep a copy for yourself.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 30 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.

Financial Assistance Application Form

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**
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 (Optional)
Mailing Address _____ _____ City State Zip Code		Main Contact Number(s) ( ) _____ ( ) _____ Email Address: _____

Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (Optional)

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?
		SELF			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_____)*

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 $_____ Medical expenses $_____

Insurance Premiums $_____ Utilities $_____

Other Debt/Expenses $_____ (*Child support, Loans, Medications, other*)

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 KCPHD2 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