FINANCIAL ASSISTANCE FOR THE UNINSURED & UNDERINSURED APPLICATION

Ocean Beach Hospital and Medical Clinics
Financial Assistance Instructions

This is an application for financial assistance (also known as charity care) at Ocean Beach Hospital and Medical Clinics.

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. *Federal Poverty Guidelines can be found on our website :www.oceanbeachhospital.com*

What does financial assistance cover? The hospital financial assistance covers appropriate hospital and clinic-based services provided by Ocean Beach Hospital and Medical Clinics 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: *Please contact our Patient Accounts representative at 360-642-6332.* 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. 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: Ocean Beach Hospital and Medical Clinics. P O Drawer H, Ilwaco WA 98624 or Fax to 360-642-6438. Be sure to keep a copy for yourself.

To submit your completed application in person: Ocean Beach Hospital and Medical Clinics 174 First Ave N, Ilwaco WA 98624 ; Phone: 360-642-6332. Office hours are: Monday – Friday 8:00am -3:30pm

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.

OCEAN BEACH
HOSPITAL
& MEDICAL CLINICS

PO Box H • Ilwaco, WA 98624 • PH: 360-642-6455 • FAX: 360-642-6435

The information listed below is required in order to process your application. Any information not provided at time of application submission, will result in a delay in the review process.

*Income information
- *Previous year tax returns (if not required to file, submit copy of SSA-1099) - or
- *Pay Stubs (most recent 3 months) or
- *Bank Statements Checking and Savings (most recent 3 months)

*Copy of Current Health Insurance Card

*Valid photo ID/Proof of current physical address

*Letter explaining financial circumstances if no income.

Ocean Beach Hospital and Medical Clinics

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** *Not required by Ocean Beach Hospital and Medical Clinics*
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*) **optional, but needed for more generous assistance above state law requirements*
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional*) **optional, but needed for more generous assistance above state law requirements*
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*_____)

Ocean Beach Hospital and Medical Clinics

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 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

Not required by Ocean Beach Hospital and Medical Clinics

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 Ocean Beach Hospital and Medical Clinics 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

FINANCIAL ASSISTANCE SLIDING FEE SCALE 2020												
AWARD	Federal Poverty Level (FPL)			100% Financial Assistance			75% Financial Assistance			50% Financial Assistance			25% Financial Assistance	
Family Size				Income from 100% FPL	Income To 150% FPL		Income From 151% FPL	Income To 200% FPL		Income From 201% FPL	Income To 250% FPL		Income From 251% FPL	Income To 300% FPL
1	FPL	12,760		0	19,140		19,141	25,520		25,521	31,900		31,901	38,280
2	FPL	17,240		0	25,860		25,861	34,480		34,481	43,100		43,101	51,720
3	FPL	21,720		0	32,580		32,581	43,440		43,441	54,300		54,301	65,160
4	FPL	26,200		0	39,300		39,301	52,400		52,401	65,500		65,501	78,600
5	FPL	30,680		0	46,020		46,021	61,360		61,361	76,700		76,701	92,040
6	FPL	35,160		0	52,740		52,741	70,320		70,321	87,900		87,901	105,480
7	FPL	39,640		0	59,460		59,461	79,280		79,281	99,100		99,101	118,920
8	FPL	44,120		0	66,180		66,181	88,240		88,241	110,300		110,301	132,360

For each additional person add 4480