



## Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as “charity care”).

Samaritan is committed to ensuring our patients get the 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.**

**What does financial assistance cover?** Appropriate and medically necessary hospital and clinic-based medical services provided by Samaritan. Eligibility is based upon information provided by you in the form of a financial assistance application and supporting income documentation. Income criteria, based on federal poverty level, will be used to determine eligibility for free or discounted care. 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 Patient Financial Services at (509) 793-9715. You may obtain help for any reason, including disability and language assistance. Translated versions of the application form is available upon request.

### **In order for your application to be processed, you must:**

- **Provide us information about your family.**
  - Complete the Family Information section below, including Family Size. Family is defined as “*people related by birth, marriage, or adoption who live together.*”
- **Provide us information about your household gross monthly income** (income before taxes and deductions).
- **Provide supporting documentation for all household income.**
  - Examples of acceptable income verification documents listed below.
- **Sign and date the form,** acknowledging that the information provided is true and correct to the best of your knowledge.

**Note: You do not have to provide a Social Security number to apply for financial assistance.** If you do not have a Social Security number, please write “not applicable” or “N/A”.

**Mail, Fax, or Email your application with all supporting income documentation to Samaritan;** ATTN: Patient Financial Services, 1616 S. Pioneer Way, Moses Lake, WA 98837, Fax to (509) 764-3244, or Email [FinancialCounselor@SamaritanHealthcare.com](mailto:FinancialCounselor@SamaritanHealthcare.com).

**To receive in-person assistance,** Patient Financial Services is located at 1616 S. Pioneer Way, Moses Lake, WA 98837. We are open Monday through Friday, 8:00 AM to 5:00 PM (except holidays).

We will notify you of the final determination of eligibility within 14 calendar days of receiving a completed financial assistance application, which must include the required supporting documentation.

We want to help! Please submit your application promptly and ensure all supporting income documentation is included. You may receive bills until that time.



# Samaritan

## Financial Assistance Application Form – confidential (page 1)

Please complete this 2 page form in its entirety. If not applicable, write "N/A." \*Attach additional pages if needed.

|   |   |
|---|---|
| Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, list preferred language: _____  | Do you receive state public services, such as TANF/Basic Food? <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| Have you applied for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>Note:</b> You may be required to apply before financial assistance consideration. | Do you currently have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, list plan name: _____ |
| Is your medical care need related to a car accident or work injury? <input type="checkbox"/> Yes <input type="checkbox"/> No  | Are you currently homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No  |

### PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- We may ask for additional supporting documentation, family information and/or proof of income.
- Within 14 calendar days of receipt of your completed application and documentation, we will notify you of your eligibility for assistance.

|  |   |   |
|--|---|---|
| Patient First Name   | Patient Middle Initial                      | Patient Last Name                           |
| <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other or N/A  | Date of Birth                               | Patient Social Security Number (optional)   |
| Guarantor (Person Responsible for Paying Bill)   | Relationship to Patient                     | Guarantor Social Security Number (optional) |
| Mailing Address<br>_____<br>_____  | Contact Number(s)<br>( ) _____<br>( ) _____ |   |
| City   | State                                       | Zip Code                                    |
| Email Address  |   |   |
| Guarantor Employment Status  |   |   |
| <input type="checkbox"/> Employed (date of hire: _____) <input type="checkbox"/> Unemployed (date of unemployment: _____)<br><input type="checkbox"/> Self-Employed <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Other (_____) |   |   |

### FAMILY SIZE

List family members in your household, **including yourself**.  
Family is defined as "people related by birth, marriage, or adoption who live together"  
\*Attach additional page if needed.

| Name | Date of Birth | Relationship to Patient | Employer Name(s) -or- Source of Income | Total Gross Monthly Income (before taxes): |
|------|---------------|-------------------------|--|--|
|      |               | <b>Self</b>             |  | \$   |
|      |               |                         |  | \$   |
|      |               |                         |  | \$   |
|      |               |                         |  | \$   |
|      |               |                         |  | \$   |

## Financial Assistance Application Form – confidential (page 2)

**REMEMBER:** All family members' income must be disclosed. Provide proof for every identified source of income.

**Source of income includes, for example:**

-Wages -Unemployment -Self-Employment -Worker's Compensation -Disability -SSI -Child/Spousal Support  
 -Pension -TANF/Basic Food -Retirement Distribution -Rental Income -Other (please explain): \_\_\_\_\_

**Supporting Documentation (i.e., "proof of income") includes, for example:**

- A "W-2" withholding statement for current year
- Current pay stubs from all employment (3 months)
- An income tax return from the most recent calendar year, including schedules (if applicable)
- Current bank statement reflecting deposit(s) for all other sources of income (3 months)
- PFMLA (Paid Family Medical Leave of Absence) deposit notification or payment statement
- Social Security Benefit award letter, Veteran Benefit award letter, Workers Compensation (L&I) award letter
- Forms approving or denying eligibility for Medicaid and/or state-funded medical assistance
- Forms approving or denying unemployment compensation
- Written statements from DSHS or other State Agency
- Retirement, Pension or Annuity Payment award letter
- Self-employment income tax forms, including schedules with Profit & Loss statement
- Samaritan Healthcare Employment Verification Form

**If you have no income, you may submit a written and signed attestation explaining your circumstances.**

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

|                              |          |                             |          |
|------------------------------|----------|-----------------------------|----------|
| Rent/Mortgage                | \$ _____ | Other Debt/Expenses (list): | \$ _____ |
| Medical or Prescription      | \$ _____ | Other Debt/Expenses (list): | \$ _____ |
| Medical Insurance Premium(s) | \$ _____ | Other Debt/Expenses (list): | \$ _____ |
| Utilities                    | \$ _____ | Other Debt/Expenses (list): | \$ _____ |

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

By submitting a financial assistance application, I give my consent to Samaritan to make necessary inquiries to confirm financial obligations and information.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I have given 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(s) Applying

\_\_\_\_\_  
Date

**Mail, Fax, or Email your application with all supporting documentation to:**

Samaritan Healthcare; ATTN: Financial Counselor, 1616 S. Pioneer Way, Moses Lake, WA 98837  
 Fax: (509) 764-3244, or Email: [FinancialCounselor@SamaritanHealthcare.com](mailto:FinancialCounselor@SamaritanHealthcare.com).

**To receive in-person assistance:**

Financial Access Specialist: 2000 S. Clover Drive, Moses Lake, WA 98837  
 Patient Financial Services: 1616 S. Pioneer Way, Moses Lake, WA 98837