Ferry County Health

Charity Care/Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as charity care) at Ferry County Health.

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. *A copy of Ferry County Health's Financial Assistance Policy is available upon request.*

What does financial assistance cover? The financial assistance covers appropriate medical services provided by Ferry County Health 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 Access Coordinator at 509.775.3333. 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:
Ferry County Health, 36 Klondike Rd, Republic, WA 99166. Be sure to keep a copy for yourself.

To submit your completed application in person: Bring completed application to any Ferry County Health front desk or to our Patient Access Coordinator located at the hospital main entrance.

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.

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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 _____)	Date of Birth:		*Patient Social Security Number:
Person Responsible for Paying Bill:	Relationship to Patient:	Date of Birth:	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)	Applying for Financial Assistance? **(Circle One)**
		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*_____)

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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
- Asset information will be used when your income is above 200% FPG
- 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*)

Be sure to include receipts and/or statements of your monthly expenses

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 Ferry County Health 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

Ferry County Health

2025 FEDERAL POVERTY GUIDELINES

Ferry County Health is required by law to have a Financial Assistance Policy for its medical services, without or at a reduced charge, to eligible persons who cannot afford to pay for care.

The full amount of hospital charges will be determined to be charity care for any patient whose gross family income is at or below 100% of the federal poverty guidelines. A sliding fee schedule below will be used to determine the amount of discount for any patient whose gross family income is between 100% and 300% of the federal poverty guidelines.

If you think you may be eligible for Financial Assistance, you may request an application from the Business Office Monday through Friday between 8:00 am and 5:00 pm. Ferry County Health will make a written conditional or final determination of your eligibility for Financial Assistance within fourteen calendar days of receiving all of your required documentation.

To be eligible for Charity Care, your family income must be at or below the following guidelines:

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Poverty Level*	**Federal Guidelines**	**200%**	**225%**	**250%**	**275%**	**300%**
Family Size		**zero fee**	**25% pay**	**50% pay**	**75% pay**	**100% pay**
1	$15,650	$31,300	$35,213	$39,125	$43,038	$46,950
2	$21,150	$42,300	$47,588	$52,875	$58,163	$63,450
3	$26,650	$53,300	$59,963	$66,625	$73,288	$79,950
4	$32,150	$64,300	$72,338	$80,375	$88,413	$96,450
5	$37,650	$75,300	$84,713	$94,125	$103,538	$112,950
6	$43,150	$86,300	$97,088	$107,875	$118,663	$129,450
7	$48,650	$97,300	$109,463	$121,625	$133,788	$145,950
8	$54,150	$108,300	$121,838	$135,375	$148,913	$162,450
For each additional person, add	$5,500	$5,500	$5,500	$5,500	$5,500	$5,500

Effective Date January 15, 2025

The Health & Human Services 2025 Poverty Guidelines information is also directly available at this website: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines