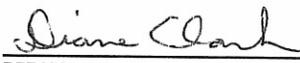
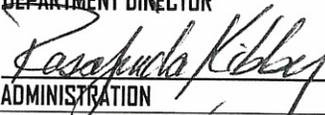


POLICY AND PROCEDURE

NUMBER: 853000-006	REVIEWED AND REVISED: 03/01/2016	EFFECTIVE DATE: 01/25/2016	SUPERSEDES NO./DATE: 11/01/2015
DISTRIBUTION: PATIENT ACCTNG, ADMITTING, SOC SERV, EMER, CLINIC, ACCTNG AND ADMINISTRATION			
SUBJECT: FINANCIAL ASSISTANCE/ CHARITY CARE POLICY		APPROVED BY:  DEPARTMENT DIRECTOR  ADMINISTRATION	

POLICY:

Columbia Basin Hospital is an open-door hospital by virtue of it's being a non-profit public Hospital District hospital. The Hospital is the community's only hospital and recognizes its obligation under the Community Service Act. Services in this facility are available to all persons without discrimination on the basis of race, color, national origin, immigration status, creed, or any other grounds unrelated to an individual's need for the service. Emergency services will not be denied because the person is unable to pay for those services. Persons receiving emergency services will, however, be billed for such services. All patients receiving services are charged for those services without discrimination between payor type or ability to pay. (see policy #853000-007.)

In order to protect the integrity of operations and fulfill this commitment, the following criteria for the provision of charity care are established, consistent with the requirements of the Washington Administrative Code, Chapter 246-453 and RCW 70.170. These criteria will assist staff in making consistent objective decisions regarding eligibility for financial assistance through the Charity Care program while ensuring the maintenance of a sound financial base.

Patients of Columbia Basin Hospital receiving Acute Care or outpatient services, or patients of Columbia Basin Family Medicine who feel they are unable to pay for their services may request financial assistance through our Charity Care Program.

PROCEDURE:

Any patient, family member, or responsible party who feels they may qualify for our Financial Assistance Program, may ask for an application at the Business Office. This application should be completed as soon as possible of the date of treatment. Hospital District personnel may suggest or offer Financial Assistance applications if they feel that the patient would meet criteria

for the Financial Assistance Program or refer the patient to the Business Office for further information on the program.

ELIGIBILITY:

Applications for financial assistance are evaluated according to the following criteria:

1. Qualification under Federal poverty guidelines that are published and updated annually. The poverty income figures in effect for the time period that the services were received will be the guideline used in making a determination of eligibility.
2. Income will include all related members of the household whether through birth, marriage, or adoption, regardless of age. Combined gross income cannot exceed 300% of the poverty guideline for uninsured persons and 200% for insured persons. (See poverty guideline attachment for most current income levels.)
 - A. Eligible persons with income below 100% of the poverty income guidelines will have their balance written off with no obligation to pay.
 - B. Persons with income from 101 – 200% of the poverty guidelines will have their balance reduced per the Reduced Payment Schedule of:

101 – 133%	75% of account balance
134 – 166%	50% of account balance
167 – 200%	25% of account balance
 - C. Uninsured persons with income between 201 – 300% of the poverty guidelines will be eligible for a reduction of charges to reduce their balance due to an amount equal to 130% of the estimated cost to charge ratio currently in effect for the Hospital. If the cost to charge ratio is equal to 77% or above, then this discount would not apply for that year.
 - D. Insured persons will be eligible for financial assistance when their income does not exceed 200% of poverty level and their balances will be reduced as listed in A and B above.
3. Columbia Basin Hospital may also consider and grant Financial Assistance for patients as a catastrophic consideration of financial assistance through the Charity Care program using the criteria for consideration as follows:
 - A. Columbia Basin Hospital charges for the patient stay total 30% of the family gross income for the year.
 - B. If the change in financial status of the applicant is temporary, the hospital may choose to suspend payments temporarily rather than initiate financial assistance reductions under the catastrophic option.
4. Determination of Financial Assistance coverage is considered on the balance after all insurance has paid for insured patients, and 100% of gross charges for uninsured patients. Uninsured patients with annual income between 201 – 300% of poverty level may be discounted based on our facility ratio of cost to charges for the prior year as noted in #2C above.

The charity application will include an income disclosure section with a request for documentation to be attached to verify the data reported. The following documents will be accepted as proof of income upon which to base eligibility: W-2 withholding statements, pay stubs from all employment, income tax return from the most recently filed calendar year, Medicaid approvals or denials, unemployment compensation notices, or written statements from employers. Determination is based on one full year's income from the time period that services were rendered.

Income is defined as: total cash receipts before taxes derived from wages and salaries, Medicaid benefits, Social Security payments, strike benefits, unemployment or disability benefits, child support, alimony, and net earnings from business and investment activities paid to the individual. Supporting documentation is needed for all forms of income listed.

If the applicant's income is below 100% of the poverty level it is not necessary to fill out the optional asset disclosure section of the application. The asset disclosure section of the application requests asset information that is required if the patient does not meet the 100% poverty guideline and wishes to be considered for a reduction in the cost of their services based on a sliding fee scale or catastrophic consideration for reduction. Asset information requested are: stocks, bonds, 401K or retirement plan, Health Savings Account balances, Trusts, Property or business ownership.

The hospital will not initiate collection efforts on an account once a request for financial assistance is received providing the responsible party is cooperative with the Hospital's efforts to reach a final determination and supplies the information necessary in order to make that determination. This is normally within 14 days of the request for assistance unless a person's medical condition may require more time.

Business Office Staff will work with the patient in order to obtain the documentation needed to complete the determination of eligibility for financial assistance. In the event that the applicant is unable to furnish the information, eligibility will be determined based on the information given and a signed statement from the applicant attesting to the correctness of the information.

In the event that hospital personnel can clearly establish that an indigent person qualifies for financial assistance, the account can be granted Financial Assistance without an application based on this determination.

THIRD PARTY PAYMENT SOURCE

Any and all insurance or third party payment sources must be exhausted prior to approval for financial assistance. All available benefit funds on such coverage must be paid to the hospital. If there is insurance coverage, an explanation of benefits or insurance information should be attached to the application form.

If a patient is uninsured, CBH personnel will assist the patient in determining whether they are eligible for Medicaid or other government sponsored health insurance programs available. Staff is available to answer questions or assist in the sign up process. If patient is found to be eligible

Policy #8531-006

for Medicaid or other no cost insurance, patient must cooperate in signing up so that services will be covered. Eligibility for Financial Assistance is determined by the patient or Guarantor's ability to pay after all available insurance has been utilized.

Balances after insurance payment may be considered for Coverage under the Financial Assistance program.

EXCLUSIONS

Elective procedures and non-emergency services will be reviewed for financial assistance consideration but are generally excluded from financial assistance through the Charity Care program.

Financial assistance and charity care shall be limited to appropriate hospital-based medical services as defined in WAC 246-453-010(7) and consist of Acute care and hospital outpatient services received at Columbia Basin Hospital, and appropriate and necessary professional services received at Columbia Basin Family Medicine. Nursing Home, Swing Bed, and Assisted Living services will not be considered for financial assistance under the Charity Care Financial Assistance Program.

Non-employee Providers consisting of: the provider who interprets your Echo test or Mammography test; or physicians from Beezley Springs Physician Services who provides care to Hospital Acute Care Inpatients are not covered under the Charity Care Financial Assistance Program of the Hospital. The patient will be billed separately for these services from the performing physician's Office.

Accounts that have been assigned to a collection agency and have a judgment granted through the court system are no longer eligible for financial assistance consideration. A patient may apply for financial assistance at any time prior to the account receiving a court judgment.

REVIEW PROCESS

Information, applications, and interviews for financial assistance will be handled by the Business Office. All requests for Financial Assistance Services will be processed within fourteen (14) business days of receipt of application and the applicant notified of the approval, denial, or need for more documentation. An application missing information needed for processing may be held up to 14 days, or such time as may reasonably be necessary from the date the applicant is notified of the need for additional documentation, in order to allow the applicant time to secure and present supporting documentation prior to receiving a determination. Missing information needed to determine eligibility may result in a denial of financial assistance until the information is received and the application can be reprocessed. Once documentation is received, the Hospital will make the determination and notify the applicant within 14 days.

Completed applications with documentation will be reviewed by the Billing/Collection Clerk with assistance from the Director of Business Services as needed. He/she will approve or

Policy #8531-006

disapprove the applications based on the documentation attached. The applicant will be sent an Eligibility Determination notifying them of the approval or disapproval, the reason for the denial, and the amount of their balance that is their responsibility.

APPEAL RIGHTS

Included in the notice of eligibility are the appeal rights. The patient has 30 days from the date of determination to request an appeal. This request must be made in writing to the Director of Financial Services providing any additional information necessary to process the reconsideration. The Director of Financial services will reconsider the application and issue a determination to the patient and Business Office. A copy will be sent to the WA Dept. of Health as per State Regulation.

PATIENT RESPONSIBILITY FOR PAYMENT

Payment arrangements will need to be set up for any balance due after receiving determination of eligibility. The applicant's financial obligation which remains after the Financial Assistance reduction is applied shall be payable as negotiated between the Hospital and the responsible party allowing a reasonable time period for payments to be made without interest or late fees. Payment plans can be transferred to Evergreen Benefit Services for monitoring of payment plans on behalf of the facility. Interest fees may be removed from these accounts.

No extraordinary collection action may be taken on approved accounts for 120 days after notice of eligibility has been sent to the patient. If payments are missed or there are periods of inactivity on the account, normal contacts may be made by the facility or its representative, Evergreen Benefit Services, in an effort to secure payment. No extraordinary collection action will be taken for 120 days from the last payment from the patient or the date of eligibility determination, whichever is greater. Extraordinary collection actions are defined as Reporting to Credit Agencies, legal processes such as regular liens, attachments, garnishments, or foreclosures, selling of debt, or denying medically necessary care because of non-payment. See policy on Bad debts for further information.

CONTINUING SERVICES

If a patient has qualified for financial assistance and continues to receive services for an extended period of time, the Hospital, at their discretion, may require the responsible party to submit a new application and documentation to ensure that they still qualify under the program.

CONFIDENTIALITY

Use and disclosure of any information contained in the request and processing of financial assistance thru the Charity Care Program shall be subject to the Health Insurance Portability and Accountability Act Privacy Regulations and the hospital's Privacy Policies.

All information and documents pertaining to the financial assistance application will be kept with the application and shall be retained for five years.

REFUNDS:

Any personal payment made on an account later determined by approval of an application to have been eligible for financial assistance will be refunded to the patient within 30 days of that approval. The patient must have been eligible at the time the payment was received.

PUBLIC NOTIFICATION:

Signs indicating the availability of financial assistance through the Charity Care program are posted in the Business Office, Clinic, Admitting, and Emergency Room areas. A Notice of Availability of Financial Assistance may also be published in the legal notices of the local newspaper or posted in the community.

The hospital will include a written notice of the availability of financial assistance to patients at the time of their first billing or statement. In addition, any letters sent for the purpose of collecting a debt will include a notice of availability of the Financial Assistance program. This will include contact information for inquiries about the program or application process. Further written information shall be made available to any person who requests it and at each Admitting/registration area.

CBH will make reasonable efforts to determine financial assistance eligibility on an account before extraordinary collection actions may occur. This includes reporting to collection agencies, legal or judicial processes, selling debt, or deferring or denying medically necessary care because of failure to pay for previous care.

This Policy as well as applications for consideration of Financial Assistance are also posted on our website at www.columbiabasinhospital.org in English and Spanish and contain contact information for applicants.

Our facility will make interpretive services available, as necessary, to provide assistance for non-English speaking patients in applying for financial assistance. Notice of availability and applications are available in Spanish versions.

Any changes to this policy will be submitted to the WA Dept of Health for approval as required by state law before changes are put into effect.

COLUMBIA BASIN HOSPITAL

Charity Care

- Minimum discount for 100 to 200 percent: 25% based on ctc 17.8%
(Based on cost to charge ratio-1-ctc)
- Minimum discount for 200 to 300 percent: 20% based on ctc 6.9%
(Based on 130% of cost to charge ratio 1-(1.3*ctc))

Based on fiscal year reported December 31, 2015

- Hospital expenses of \$ 16,013,555
Calculated as total operating expenses minus other operating revenue
- Hospital Revenue of \$ 19,477,007
Reported as total patient revenue
- Ratio of costs to charges is 82,2%

Note: if cost to charge ratio is under 100%, no charity discounts needed over 200% of poverty level.

COLUMBIA BASIN HOSPITAL AND COLUMBIA BASIN FAMILY MEDICINE

provides hospital care regardless of ability to pay.

You can get help with Hospital and Clinic Bills!

Financial Assistance Program

What are hospital financial assistance and charity care? Hospital financial assistance is available to help people and families in Washington pay for hospital services. Financial assistance may provide either free or reduced-price care, depending on your eligibility and income.

Who receives financial assistance?

1. To receive financial assistance your income level must be within our guidelines.
2. If your income is within our guidelines, you can get assistance even if you are insured but the insurance does not cover all the costs of your care.
3. To receive financial assistance you *cannot* be involved in a work related injury or auto accident or similar situation where someone else has a legal responsibility to pay for the costs of hospital care.
4. You can receive financial assistance regardless of race, creed, color, national origin, sex, sexual orientation, or the presence of any sensory, mental, or physical disability or the use of a trained dog guide or service animal by a disabled person.

What does Financial Assistance cover? Financial assistance will cover medically necessary hospital care, including inpatient and outpatient care. Some Physician services may also be covered.

Financial assistance programs do *not* cover transportation costs or care that is not medically necessary such as cosmetic procedures, and usually do not cover all physician services. Long Term Care services such as Nursing Home or Assisted Living are not eligible for this program.

How do I apply? To receive an application and find out what is needed to prove eligibility, or questions about services that will be covered, please contact:

The Business Services Department
Located in the Administration Building
Or call : 509-717-5219

More information at: www.columbiabasinhospital.org

You may also request an estimate of charges prior to receiving services.

Please ask us!

Grant County Public Hospital District #3 Notice of Availability of Financial Assistance

Grant County Public Hospital District #3 is committed to the provision of health care services to all persons in need of medical attention, regardless of ability to pay. Patients with no adequate means of paying for needed care – will be granted financial assistance in accordance with the District's charity care and non-discrimination policies.

Columbia Basin Hospital and Columbia Basin Family Medicine has available a limited amount of Financial Assistance to cover necessary or emergency medical treatment for persons eligible under charity care guidelines. It does not cover transportation costs or elective procedures.

Eligibility for Financial Assistance is determined by measuring personal and family income and assets against the established Federal Income Guidelines. If your income is below 300 percent of the federal poverty level and you have exhausted any other health care coverage available to you, then you should qualify for free or discounted medical services.

If you wish to apply for assistance, please contact our Business Office as soon as possible after receiving medical treatment. You will be asked to fill out a personal financial statement and furnish proof of your income. A denial of eligibility from Medicaid may also be required. You may use W-2 forms, pay check stubs, income tax returns, etc. as part of your proof of income.

If you qualify, your medical bill may be reduced or written off. You will receive a written determination of eligibility within 14 business days following receipt of your completed application, when accompanied by your financial statement and proof of income.

Please contact the Business Office with any questions you may have at 509-717-5219. Information is also available at www.columbiabasinhospital.org.

Gross Annual Family Income

Family Size	100%	75%	50%	25%	-0-
01	Less than \$11,880.	\$11,881.-\$15,694.	\$15,695.-\$19,721.	\$19,722.-\$23,759.	\$23,760.
02	Less than \$16,020.	\$16,021.-\$21,307.	\$21,308.-\$26,593.	\$26,594.-\$32,039.	\$32,040.
03	Less than \$20,160.	\$20,161.-\$26,813.	\$26,814.-\$33,466.	\$33,467.-\$40,319.	\$40,320.
04	Less than \$24,300.	\$24,301.-\$32,319.	\$32,320.-\$40,338.	\$40,339.-\$48,599.	\$48,600.
05	Less than \$28,440.	\$28,441.-\$37,825.	\$37,826.-\$47,210.	\$47,211.-\$56,879.	\$56,880.
06	Less than \$32,580.	\$32,581.-\$43,331.	\$43,332.-\$54,083.	\$54,084.-\$65,159.	\$65,160.
07	Less than \$36,730.	\$36,731.-\$48,851.	\$48,852.-\$60,972.	\$60,973.-\$73,459.	\$73,460.
08	Less than \$40,890.	\$40,891.-\$54,384.	\$54,385.-\$67,877.	\$67,878.-\$81,779.	\$81,780.

Add \$4,160. for each additional family member.

Based on 2016 Federal Poverty Guidelines
Effective 012516 received 02032016

2016
Federal Poverty Guidelines

Family Size	100%	200%	300%
01	11880.	23,760.	35,640.
02	16,020.	32,040.	48,060.
03	20,160.	40,320.	60,480.
04	24,300.	48,600.	72,900.
05	28,440.	56,880.	85,320.
06	32,580.	65,160.	97,740.
07	36,730.	73,460.	110,190.
08	40,890.	81,780.	122,670.

For family units with more than 8 members, add \$4,160. for each additional member.

2016 Federal Poverty Guidelines: Gross Annual Income
Effective 012516 received 02032016



STATE OF WASHINGTON

DEPARTMENT OF HEALTH

CENTER FOR HEALTH STATISTICS

PO Box 47814 • Olympia, Washington 98504-7814

Tel: (360) 236-4300 • Fax: (360) 753-4135

February 2, 2016

2016 Federal Poverty Guidelines

The Federal Register published and made effective January 25, 2016, the 2016 Federal Poverty Guidelines for all states. Alaska and Hawaii are listed separately.

These guidelines are to be used by hospitals for calculating charity care eligibility under Revised Code of Washington (RCW) 70.170

2016 HHS Poverty Guidelines

Persons in Family	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$11,880	\$14,840	\$13,670
2	16,020	30,020	18,430
3	20,160	25,200	23,190
4	24,300	30,380	27,950
5	28,440	35,560	32,710
6	32,580	40,720	37,470
7	36,730	45,920	42,230
8	40,890	51,120	47,010
For each additional person, add	4,160	5,200	4,780

The Federal Register notice is at this link:

<https://www.federalregister.gov/articles/2016/01/25/2016-01450/annual-update-of-the-hhs-poverty-guidelines>

The Health & Human Services 2016 Poverty Guidelines information is also directly available at this website: <https://aspe.hhs.gov/poverty-guidelines>.

Please contact Ric Ordos at (360) 236-4216 or email Ric.Ordos@doh.wa.gov if you have any questions.

Richard Ordos, Supervisor
DOH/DCHS/CHS/Hospital & Patient Data Systems

Grant County Public Hospital District #3
Columbia Basin Hospital
Columbia Basin Family Medicine

Financial Assistance Program Eligibility Determination

Your Financial Assistance Application has been processed and the following determination was made:

_____ The applicant is eligible for Financial Assistance. Your total charges in the amount of \$ _____ will be dismissed.

_____ The applicant is eligible for a partial reduction of their total charges.
\$ _____ will be dismissed as Financial Assistance.
\$ _____ will be still due from the applicant.

Please contact our Business Office to make arrangements for payment of the balance still owing.

_____ The applicant's request for Financial Assistance has been denied for the following reasons:

If your request for Financial Assistance is denied, you may, within 30 days of the receipt of this notice, file an appeal, or request for reconsideration of your application. This request must be made in writing to:

Director of Financial Services
Columbia Basin Hospital
200 Nat Washington Way
Ephrata, WA 98823

Please provide any additional information or verification needed in order to process your reconsideration. If this determination affirms the previous denial of Financial Assistance, written notification will be sent to you and to the WA State Department of Health in accordance with State Charity Care law.

Signature

Date of Determination & notice to applicant

Date Application Received

Type of Income verification: _____

**Columbia Basin Hospital
Columbia Basin Family Medicine
Financial Assistance Application Form Instructions**

This is an application for financial assistance at Columbia Basin Hospital and Columbia Basin Family Medicine.

Financial assistance is available to people 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. The State requires all hospitals to provide financial assistance. You may view hospital policy #853000-006 on our website at www.columbiabasinhospital.org for eligibility and sliding fee schedule information or request a copy from our Business Office by calling 509-717-5219.

What does financial assistance cover? The Hospital Financial Assistance program covers medically necessary hospital and clinic services provided by Columbia Basin Hospital and Columbia Basin Family Medicine, depending on your eligibility. Financial assistance may not cover all healthcare costs, including services provided by other organizations.

If you have questions or need help completing this application: Contact the Business Office at 509-717-5219 or 509-717-5210 or you may come in to the office at 200 Nat Washington Way, Ephrata, WA 98823. Interpreter services are available to assist you.

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

- 1) **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)
- 2) **Provide us information about your family's gross monthly income** (income prior to taxes and deductions)
- 3) **Provide documentation for family income and declare assets**
- 4) **Attach additional information if needed**
- 5) **Sign and date the form**

Note: 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". Not having a social security number will not exclude you from eligibility for financial assistance.

Mail completed application with all documentation to: Columbia Basin Hospital, Business Office, 200 Nat Washington Way, Ephrata, WA 98823.

To submit your completed application in person: Return to the Business Office located in the Administration Building at 200 Nat Washington Way, Ephrata, WA We are available Monday thru Friday 8:00 am – 5:00 pm.

We will notify you of the final determination of eligibility 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 completed application promptly! You may receive bills until we receive your completed application and supporting documents.

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 \$ _____

Medical expenses \$ _____

Utilities \$ _____

(child support, loans, medications, other)

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, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that Columbia Basin Hosp 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 information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.

Signature of Person Applying

Date

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	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (may specify _____)		Birth Date		Social Security Number (optional*)	
Person Responsible for Paying Bill		Relationship to Patient	Birth Date	Social Security Number (optional*)	
Mailing Address				Main contact number(s)	
City		State		Zip Code	
				() _____ () _____ Email Address: _____	
Employment status of person responsible for paying bill					
<input type="checkbox"/> Employed (date of hire: _____) <input type="checkbox"/> Unemployed (how long unemployed: _____) <input type="checkbox"/> Self-Employed <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> 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* _____)