



NORTH GILLIAM COUNTY HEALTH DISTRICT

NORTH GILLIAM MEDIC

PO Box 105 | Arlington, OR 97812-0105

Tel: (541) 454-2888 | Fax: (541) 454-2988

Individual Written Notice of Financial Assistance

It is the policy of North Gilliam County Health District that no person will be denied needed emergency medical care because of an inability to pay for such services.

North Gilliam County Health District will provide needed emergency services without charge or at a reduced charge and without discrimination to those persons with no or inadequate means to pay for needed care.

You may qualify for financial assistance if you have been granted financial assistance by the medical facility where you were transported.

If you think you may be eligible for Financial Assistance, please complete and sign the application **on the reverse side of this page**, attach documentation for any listed income or grant of "hospital charity," and send to:

North Gilliam County Health District
c/o Systems Design
PO Box 3510
Silverdale, WA 98383-3510

You will be notified of any reduction in your bill once the Fire District has reviewed your application.

FINANCIAL ASSISTANCE APPLICATION

PATIENT INFORMATION

Name:		
Date of Service:	Transported to:	Phone:
Current Address:		
City:	State:	ZIP Code:

RESPONSIBLE PARTY INFORMATION

Name:	
Relationship:	
Current Employer:	Employed From:
Previous Employer:	Employed From:
Spouse Employer:	Employed From:
Spouse Previous Employer:	Employed From:

INCOME

Family Member 1	Family Member 2	Family Member 3
Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
Wages:	Wages:	Wages:
Self-Employment:	Self-Employment:	Self-Employment:
Public Assistance:	Public Assistance:	Public Assistance:
Social Security:	Social Security:	Social Security:
Unemployment:	Unemployment:	Unemployment:
Worker's Comp.:	Worker's Comp.:	Worker's Comp.:
Alimony:	Alimony:	Alimony:
Child Support:	Child Support:	Child Support:
Pension/Retirement:	Pension/Retirement:	Pension/Retirement:
Dividend Income:	Dividend Income:	Dividend Income:
Rental Prop. Income:	Rental Prop. Income:	Rental Prop. Income:
Other Income (detail):	Other Income (detail):	Other Income (detail):
Total Income:	Total Income:	Total Income:

Please attach documentation of any listed income such as W-2s, pay stubs, tax returns, forms approving or denying eligibility from Medicaid and/or state-funded medical assistance, forms approving or denying unemployment compensation or written statements from employers or welfare agencies.

Was Charity Care granted by the receiving medical facility? *Please circle.* **YES** **NO**

The above information is correct to the best of my knowledge. I authorize North Gilliam County Health District to verify for the purpose of financial assistance eligibility determination.

Signature (Patient or Responsible Party):	Date:
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ADMINISTRATIVE REVIEW

Total Balance Billed:	Payments Made:
Current Account Balance:	Adjustments (By EMS):
New Balance:	
Signature (North Gilliam County Health District):	Date: