SKAMANIA EMERGENCY MEDICAL SERVICES & RESCUE

SKAMANIA COUNTY PUBLIC HOSPITAL DISTRICT

253 SW First Street ● PO BOX 338 ● Stevenson, Washington 98648

Office: 509-427-5065 Fax: 509-427-2767 Email: info@skamaniaems.com

Dear Patient and Family:

Under the guidance of Washington Administrative Code, 246-453, and the Revised Code of Washington, Title 70, Chapter 70.170, Skamania EMS & Rescue applies a policy related to Charity Care and financial assistance. This policy applies to "indigent persons" as described in WAC 245-453-040 and utilizes the income guidelines provided by the US Department of Health and Human Services.

These income guidelines are published and updated here: https://aspe.hhs.gov/

Charity Care is a form of financial assistance that covers medically necessary services provided by Skamania EMS & Rescue. This assistance **may or may not** cover all health care costs, including services provided by other organizations, rescue services and motor vehicle extrication services.

In order to apply for Charity Care you must provide the following:

1. Information about your family
    a. Including the number of family members (related by birth, marriage or adoption) who live in your household
2. Information about your families gross monthly income (all persons in the home who are 18 years of age or older)
3. A declaration of assets
4. Additional information which may be requested to verify income or financial need
5. Consent for us to make the necessary inquiries to confirm financial obligations and information.
6. A completed, signed and dated Charity Care Application.

Please note, Skamania EMS & Rescue will not require you to provide your social security number to obtain Charity Care. If you do provide it, it may speed up processing of your application, as these numbers may be used to verify information provided to us. If you do not have a social security number or would like to decline to provide it, please mark N/A on the Charity Care Application.

The completed Charity Care Application and required documentation should be mailed to us (address noted above) or dropped of in person at Skamania EMS & Rescue, 253 SW First Street, Stevenson, Washington. ****We recommend you maintain a copy for your records.****

Following review of your application, Skamania EMS & Rescue will notify you within 45 calendar days and the balance of your account, of portion thereof, will be written off **if it is determined you are eligible for Chairity Care or financial assistance.**

For your convenience, the Charity Care Application follows (as page 2) of this document. Please send any inquires to info@skamaniaems.com

Charity Care / Financial Assistance Application

SCREENING INFORMATION

Do you need an interpreter? ☐ Yes ☐ No Preferred Language:

Has the patient applied for Medicare or Medicaid? ☐ Yes ☐ No

Does the patient receive state assistance such as TANF, SNAP Food Assistance, WIC? ☐ Yes ☐ No

Is the patient currently homeless? ☐ Yes ☐ No

Is the patient's medical care related to a car accident or work injury? ☐ Yes ☐ No

DISCLOSURE

Skamania EMS & Rescue cannot gurantee 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 45 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION

Patient Name (Last, First, Middle):

Gender: ☐ Male ☐ Female ☐ Other (may specify_____) ☐ Decline to Answer

Date of Birth:	Social Security # (Optional):
Patient Email:	Patient Phone #:
Name of Person Responsible for Paying Bill:	Relationship to Patient:
Mailing Address of Responsible Payor:	Phone Number of Payor:
Patient Health Insurance Information:	

Employment Status of person responsible for paying the bill:

☐ Employed (date of hire:_____) ☐ Unemployed (how long?_____)

☐ Self-Employed ☐ Student ☐ Disabled ☐ Retired ☐ Other

PATIENT AND APPLICANT INFORMATION (Continued)

List family members livng in your household, including you. Family includes people related by birth, marriage, or adoption who live together in the same home.

Name	Date of Birth	Relationship to Patient	Employer Name	Total Gross Monthly Income

All adult family members living in the same household as the patient and their income must be disclosed. Sources of income include, for example: Wages, unemployment, self-employment, workers compensation, disability pay, SSI, child/spousal support, pensions, retirement distributions.

INCOME INFORMATION (Documents Required for Verification)

You must provide information on your family's income. Income verification is required to determine financial assistance. **All family members 18 years of age 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 include:**

- A W2 withholding statement from the most current tax year
- Current paystubs (3 months)
- Most current tax year income tax return, including schedules, if applicable
- Written, signed statements from your employer or others verifying your work status and income
- Approval/denial of eligibility for Medicare/Medicaid or State funded medical assistance
- Approval/denial for unemployment compensation

MONTHLY EXPENSES (We use this information to get a more complete picture of your situation)

Monthly Household Expenses:

☐ Rent/Mortgage _____

☐ Insurance _____

☐ Other Debt Payments _____ (child support, loans, etc.)

☐ Medical Expense _____

☐ Utilities _____

Total: _____

ASSETS (This information may be used if your income is ≥200% of the Federal Poverty Guidelines)

Current Assets:

☐ Checking Account Balance _____

☐ Savings Account Balance _____

Other Assets, Check All that Apply:

☐ Stocks ☐ Bonds ☐ 401K ☐ Health Savings Account ☐ Health Reimbursement Account

☐ Property (excluding primary residence) ☐ Own a Business

PATIENT / PAYOR AGREEMENT

I understand that Skamania EMS & Rescue or their third party claims administrator may verify information by reviwing credit information and obtaining information from other sources to assist in determining eligibility for Charity Care and/or other financial assistance, or payment plans. I affirm that the above information is true and correct to the best of my knowledge. I understand the information I give is determined to be false, the result will be denial of Charity Care and/or other financial assistance, and I will be responsible for and expected to pay for services provided.

_____ _____

Signature of Patient/Applicant (Patients Representative) Date