Gritman MEDICAL CENTER

GRITMAN MEDICAL CENTER
Financial Assistance (Charity Care) Application Form Instructions

Gritman Medical Center is committed to providing access to health care services to all persons in need regardless of ability to pay. Our complete Financial Assistance Policy can be viewed at: http://www.gritman.org/billing-assistance.aspx and is available in paper form at Gritman Medical Center, Kendrick Family Care Clinic, Troy Clinic, Internal Medicine Clinic, Potlatch Family Care Clinic, Moscow Family Medicine Downtown, Moscow Family West Side, Moscow Family Quick Care, and Moscow Family Student Health Center.

Financial assistance will be approved for health care services to patients who qualify based on information provided in this application or to patients who have been determined to be presumptively eligible. In addition, financial assistance may be provided in other circumstances on a case-by-case basis as determined by the Chief Financial Officer or Chief Executive Officer.

Note: *Failure to comply with Medicaid requirements, the Idaho "County" Medically Indigent Program, privately funded plans/programs, or failure to disclose other government or privately funded programs, may result in denial of Financial Assistance.*

For questions or help completing this application:
Please reach out to one of our Financial Counselors via phone (208) 883-2223 or visit Gritman Medical Center, 700 S Main, Moscow, ID 83843.

You are not required to provide a social security number (SSN) to apply for financial assistance.
However, by providing your SSN we are able to verify information included in this application and decrease the number of days needed to process the application. If you do not have a SSN, please mark "not applicable" or "NA".

Please return your completed application within 30 days using one of the following methods:

- In person to the Patient Accounting Department at 700 S Main St, Moscow, ID 83843;
- By mail to the Patient Accounting Department, PO BOX 8007, Moscow, ID 83843;
- By email to financialcounselor@gritman.org;
- Or by fax to ATTN: Financial Counseling at (208) 883-6517.

Applications will not be considered if incomplete documentation is provided, including but not limited to, the fully completed/signed application and documentation verifying income as specified on page three (3) under the "Income Information" heading.

We will notify you of the final determination of eligibility and appeal rights within 30 calendar days of receiving a completed financial assistance application, including documentation of income.

We want to help. Please submit your application promptly!
You may receive bills until we receive your information.

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*****For Internal Use Only*****	
Date Sent:	Date Returned:

Financial Assistance (Charity Care) Application Form – Confidential

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION

Has the patient applied for Medicaid, the Idaho County Program, and/or Pregnant Women and Children Program (PWC), if applicable? □ **Yes** □ **No**	If so, which program(s)?
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

- By completing this application, you are not guaranteed to qualify for financial assistance.
- We may ask for additional information once your completed application and supporting documents have been reviewed.
- Outpatient primary care; Kendrick Family Care Clinic, Internal Medicine Clinic, Potlatch Family Care Clinic, Troy Clinic, Moscow Family Medicine Downtown, Moscow Family West Side, Moscow Family Quick Care, Moscow Family Student Health Center, and Emergency Department visits base eligibility for discount on income and family size only.
- You will be notified of the final eligibility determination within 30 calendar days after we receive your completed application.
- Application(s) to Medicaid, the Idaho County Program and/ or Pregnant Women and Children Program (PWC) may be required before being considered for financial assistance.

PATIENT AND APPLICANT INFORMATION

Patient First Name	Patient Middle Name		Patient Last Name
	Patient Date of Birth		Patient Social Security Number* **optional, but may be needed to verify your information*
Person Responsible for Paying Bill	Relationship to Patient	Date of Birth	Social Security Number* **optional, but may be needed to verify your information*
Mailing Address of Responsible Party: Address: _____ City _____ State _____ Zip Code _____			Main phone 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** (_____)

Household Information (list each member)	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):

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Charity Care/Financial Assistance Application Form – Confidential

INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application.*

Household income must be provided including income verification, to determine financial assistance. All family members 18 years old or older must disclose their income.

Please provide proof for every identified source of income.

- **Current pay stubs or unemployment pay (2 months);**
- **Current bank statements (2 months); if account is closed, provide a letter from bank stating date closed;**
- **Last year's income tax return. If you are claimed on someone else's tax return as a dependent, please provide a copy of that person's tax return.**
- **All applicable withholding statements (W-2's)**
- **Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or**
- **Approval/denial of eligibility for unemployment compensation.**

If you are unable to provide proof of income or have no income, please submit a written statement describing your income status.

EXPENSE INFORMATION

This information is used to further understand your financial situation.

Monthly Household Expenses:

Rent/Mortgage $_____

Insurance Premiums $_____

Other Debt/Expenses $_____ (*child support, loans, medications, other*)

Medical Expenses $_____

Utilities $_____

ASSET INFORMATION

This information is used to further understand your financial situation.

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

If there is additional 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 please attach an additional page detailing those circumstances.

PATIENT AGREEMENT

I understand that Gritman Medical Center 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

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