LAKE CHELAN COMMUNITY HOSPITAL & CLINICS

Dear Patient,

You have requested financial assistance for one or more accounts for services provided by Lake Chelan Community Hospital & Clinics. Please complete the attached application and submit with the required documentation for consideration of one of our available Financial Assistance Programs.

Our Financial Counselor is available for personal assistance by appointment. During this time, they can screen and assist with finding the best resolution for your individual needs. Additionally, they are able to assist patients in applying for Medicaid or other local and state programs.

It is our privilege to assist you through this process to find the best solution for you.

Please note the following information:

- If you need assistance to complete this application, please contact our Financial Counselor to schedule an appointment.
- All properly submitted applications will be processed within 10 business days of receipt. A final letter of determination will be provided.
- Any incomplete applications will be returned upon receipt with a letter advising what information is needed in order to process the application.
- Any application submitted for Charity Care consideration that does not qualify will automatically be considered for our Discount Payment or Reasonable Payment programs; a separate application is not necessary.

Return your completed application with <u>all supporting documentation</u> within 30 days of receipt of the application. Applications may be mailed, emailed, or faxed to the following:

Lake Chelan Community Hospital & Clinics
Attn: Patient Financial Counselor
503 E. Highland Ave.
Chelan, WA 98816

Email: financialcounseling@lcch.net
Fax: 509-682-3475, Attention: Patient Financial Counselor

Thank you for choosing Lake Chelan Community Hospital & Clinics for your healthcare needs. We look forward to assisting you.

Warm Regards,

Financial Counselor
(509)682-6103

LAKE CHELAN COMMUNITY HOSPITAL & CLINICS

1. Responsible Party Information

Last Name	First Name	Social Security #	Date of Birth
Home (Physical Address)	Mailing Address	City	State Zip
Home Phone #	Alternate/Cell Phone		
Employer Name	Employer Address		Employer Phone
Job Function/Title		Gross Annual Income	
Spouse's Name		Social Security #	Date of Birth
Employer Name	Employer Address		Employer Phone
Job Function/Title		Gross Annual Income	

2. People In Family/Household (Include only those that you claim on your taxes)

	Name	Relationship to applicant	Date of Birth	Employer	Annual Gross Income
1					
2					
3					
4					
5					
6					
7					

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3. Income & Asset Information

In order to determine the extent of your eligibility for one of Lake Chelan Community Hospital & Clinics Financial Assistance Programs, please complete the sections below. Please note, different information is required for each program.

- **Monthly Income: Required for Discount Payment (Sliding Fee) Program, Reasonable Payment Plan, and Charity Care.**

Job Income:	$
Spouse Income:	$
Social Security/Disability:	$
Business/Rental Income:	$
Interest/Dividend Income:	$
Alimony and/or Support:	$
Other Income:	$
Total Monthly Income:	**$**

Required Documentation

At least one of the following must be submitted:

- All paystubs from the last 90 days;
- Most current W-2 for all working adults;
- Copy of the most recently filed tax return;
- Social Security Statement(s)
- If no income, please attach a signed letter explaining circumstances.

- **Currently Monthly Essential Living Expenses: Required for Reasonable Payment Plan**

Mortgage/Rent:	$
Utilities (gas, water, electric, phone)	$
Insurance (health, auto, home):	$
Food:	$
Medical Bills with payment plans:	$
Other:	$
Total Monthly Income:	**$**

Required Documentation

- Please include most current statements for any expense listed/claimed on this application;
- Receipts/proof of payment for amounts paid for food and medical expenses paid within the past 12 months. If no receipts are available for food, an average of $150.00 per person.

By signing below, you agree to be considered for Lake Chelan Community Hospital & Clinics Discount Payment Program, Reasonable Payment Program, and/or Charity Care Program. Additionally, you certify that all of the statements and information provided on this application are true and complete to the best of your knowledge. Should it be determined that the information you provided is incomplete or false, any discount applied may be reversed and payment in full may be expected from you. By signing below, you authorize Lake Chelan Community Hospital & Clinic to check references and credit history in order to determine eligibility.

You further agree by signing below, that if you receive payment from an insurance company, worker's compensation plan, or any other third party, to inform Lake Chelan Community Hospital & Clinics to any such payment. Lake Chelan Community Hospital & Clinics retains the right to collect the original, full billed amount for rendered services should a third-party provide proof of coverage.

_____ _____

Signature Date