Mid-Valley Hospital

Effective:	*11/2000*
Approved:	*09/2021*
Last Revised:	*09/2021*
Due For Review:	*09/2022*
Author:	*Jerri Dion: Director of Revenue Cycle*
Policy Area:	*Business Office*
References:	

Healthcare Assistance Program

POLICY:

Mid Valley Hospital is committed to serve, without exclusion, and to provide appropriate hospital-based medical services to all persons in need of medical attention, regardless of ability to pay. Mid Valley Hospital's Health-care Assistance Program offers free or discounted care to individuals who meet the established criteria. Medically necessary charges that exceed a patient's ability to pay and which are not covered by any third party payment sources, including Medicare and Medicaid, shall be considered eligible for application to the Health Care Assistance Program (HAP).

In order to protect the integrity of the operations and fulfill this commitment, the following criteria for the provisions of HAP have been established. These criteria will assist the staff in making consistent and objective decisions regarding eligibility for HAP, while ensuring the maintenance of a sound financial base.

SCOPE:

Director of Revenue Cycle, Chief Financial Officer and Administrator

RESPONSIBILITIES:

Director of Revenue Cycle, Chief Financial Officer and Administrator

CONTROL:

Director of Revenue Cycle, Chief Financial Officer and Administrator

A. POLICY AND DEFINITIONS

- Policy and definitions shall conform to those described in WAC 246-453 **& RCW 70.170**
- Abbreviations used in this document: Health care Assistance Program Application (HAPA), Patient Account Representative (PAR), Director of Revenue Cycle (DRC).

B. NOTIFICATION

- Notice shall be made publicly available through the posting of signs in public areas of the hospital and clinic, including Admissions/and or Registration, the emergency department, Billing/Financial services, that charges for services provided to those persons meeting the criteria established within WAC 246-453-040 may be waived or reduced.
- The hospital/clinic will provide verbal communication to all patients informing them about the

availability of HAP at the time of admission.

- Information regarding HAPA will be posted on every statement generated and made available on Mid Valley Hospital and Mid Valley Clinic websites in a easy to read summary in both English and Spanish.

C. ELIGIBILITY CRITERIA

- HAP is secondary to any other financial resources available to the patient including a government subsidized program, third party liability carriers or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical service.
- In those situations where appropriate primary payment sources are not available, patients may be considered for HAP based on the following criteria:

a. All responsible parties with family income equal to or below one hundred percent of the federal poverty standard, adjusted for family size, shall be determined to be indigent persons qualifying for HAP sponsorship for the full amount of charges related to medically necessary clinic or hospital-based medical services that are not covered by private or public third-party sponsorship; (WAC 246-453-040[1]). Please refer to chart at the end of this Policy.

b. All responsible parties with family income between one hundred one and two hundred percent of the federal poverty standard, adjusted for family size, shall be determined to be indigent persons qualifying for discounts from charges related to medically necessary clinic & hospital-based medical services in accordance with Mid Valley's sliding fee schedule and policies regarding individual financial circumstances; (WAC 246-453–040[2]). Attached at end of this policy.

c. All deceased patients will be verified by certificate of death or death notice in newspaper along with verification of no estate filed with county and/or a letter from the family indicating no estate exists.

d. If a patient has qualified for HAP and continues to receive services for an extended period of time, the hospital, at it's discretion, may require the responsible person to reapply for assistance at anytime, including any time is a change in a patient's financial circumstances.

e. Timing of Income Determinations: Annual Family Income of the Applicant will be determined as of the time the Appropriate Medically Necessary Hospital based medical services were provided, or at the time of application for Health Assistance if the application is made within two years of the time the appropriated hospital-based medical services were provided, the applicant has been making good faith effort towards payment for the services and applicant demonstrates eligibility for assistance..

f. Family is defined as a group of two or more persons related by birth, marriage, or adoption who live together. Documentation of income can be requested of members of the family over 18.

g. Income is defined as total cash receipts before taxes derived from wages and salaries, welfare payments, Social Security payments, strike benefits, unemployment or disability benefits, child support, alimony and net earnings from business and investment activities paid to the individual.

D. CATASTROPHIC HEALTH ASSISTANCE

E. The hospital may also assign HAP in those instances when families with income in excess of two hundred percent of the federal poverty guidelines are in circumstances which indicate severe personal hardship or personal loss, e.g. death of primary wage earner or extreme, catastrophic medical services subsequent to the date of service. Determination shall be make on a case-by-case basis and at the discretion of the

DRC, in accordance with WAC 246-453-030(3) and WAC 246-453-030(4).

PROCEDURE:

A. IDENTIFICATION OF POTENTIAL HEALTH CARE ASSISTANCE PROGRAM (HAP) RECIPIENTS AT TIME OF ADMISSION
RESPONSIBILITY: Admitting Staff

1. At time of admission or registration, admitting staff will offer the HAP to each patient or responsible party and indicate on the electronic form provided at time of registration whether application was accepted or rejected.
2. All HAPA's will be forwarded to the Patient Account Representative (PAR) on a daily basis.
3. In the event that a patient is unable or has not been screened during the course of the admission, the financial counselor is expected to review all potential uncompensated accounts and conduct a financial screening with the guarantor and initiate HAP when appropriate.

B. PROCESSING HEALTH CARE ASSISTANCE PROGRAM APPLICATIONS (HAPA)
RESPONSIBILITY: Patient Account Representative (PAR)

C. 1. All applications, whether initiated by the patient or hospital, should be accompanied by documentation to verify income as indicated on the application form. Any one of the following documents shall be considered sufficient evidence upon which to base the final determination of charity care eligibility:

   a. Payroll check stubs
   b. Bank statements for the last six months
   c. Income tax returns for recent year with W2 withholding statement
   d. Unemployment benefits
   e. Proof of Social Security Benefits

2. The PAR will conduct a financial screening to determine if the patient is potentially eligible for State or Federal funding, example, Medicaid or SSI Medicare. If their medical history or personal status indicates potential benefits, the guarantor will be asked to apply for this funding before processing HAPA's. During the determination process for our HAP, all collection efforts will be ceased, in accordance with WAC 246-453-020(9)(b).
3. The guarantor will be asked to provide income verification documents within 30 days from the date the patient received the HAPA, or such time as the person's medical condition may require, or such time as may reasonably be necessary to secure and to present documentation prior to receiving a final determination of sponsorship status. The failure of a responsible party to reasonably complete the appropriate application procedures shall be sufficient grounds for the hospital to initiate collection efforts directed at the patient.
4. Using the above information, the PAR will evaluate the income information and, based on the patient's ability to pay at that time and with the Sliding Payment Scale, verify the amount of write-off or denial. Refer to last page of this Policy.
5. Upon receipt of all verification documentation from the patient, the PAR shall *review* and determine the percentage of the adjustment, make the appropriate adjustment using the appropriate transaction code that corresponds with the General Ledger, and a work item will be sent to the Director of

Revenue Cycle for review, approval or denial.

6. After review by the DRC the PAR will send written notice to the applicant of denial or approval within fourteen (14) days. If the application is denied, the PAR will notify the patient, in writing, advising guarantor of the reason for the denial and also advising them of the appeal process.
7. Each month a report will be ran and submitted to the Board of Commissioners for approval.
8. After determination of the HAPA, any financial obligation that is owed shall be payable in monthly installments over a reasonable period of time. The responsible party will not be turned over to a collection agency unless payments are missed and no satisfactory contact has been made with the responsible party. WAC 246-453-050(1)(c).

D. IDENTIFICATION OF HEALTH CARE ASSISTANCE PROGRAM ACCOUNTS DURING PRE-COLLECTION ACTIVITY
RESPONSIBILITY: Patient Account Representative

1. The Patient Account Representative (PAR), in the course of pre-collection activity, may identify potential HAP accounts. The PAR will send a Notice of HAP in the pre-collect letter to the patient's guarantor.
2. Upon receipt of the completed HAPA, follow guidelines as outlined in B1-B7, above.

E. HEALTH CARE ASSISTANCE PROGRAM (HAP) APPROVAL AUTHORITY LEVELS & Training

1. All balances will be tentatively approved on a daily basis by the Director of Revenue Cycle.
2. The Board will review and approve all write-offs during regularly scheduled Board Meetings.
3. MVH/MVC patient account representatives will receive yearly training in the Health Care Assistance Program in order for them to be able to assist patients with questions or concerns.

F. APPEAL PROCESS

1. All applications will receive written notice of denial within fourteen (14) days of HAP application. WAC 246-453-030.
2. Patients/Guarantor may appeal by writing a letter explaining why they feel the denial is inappropriate and or by supplying additional information to support a favorable decision.
3. Upon denial, the patient shall be given thirty (30) days to appeal the decision.
4. Appeals should be directed to the DRC, who will invite a review committee to and shall be responded to within ten (10) business days from date of receipt.
5. If it is found that the denial stands, the responsible party and the department of health shall be notified in writing of the decision and the basis for the decision, and the department of health shall be provided with copies of documentation upon which the decision was based.
6. The hospital should make every reasonable effort to reach initial and final determinations of HAP designation in a timely manner; however, the hospital shall make those designations at any time upon learning of facts or receiving documentation, as described in WAC 246-453-030, indicating that the responsible party's income is equal to or below two hundred percent of the federal poverty standard as adjusted for family size. The timing of reaching a final determination of HAP status shall have no bearing on the identification of HAP deductions from revenue as distinct from bad debts.
7. In the event that a responsible party pays a portion or all of the charges related to appropriate hospital based medical care services, and is subsequently found to have met the HAP criteria at the time that services were provided, any payments in excess of the amount shall be refunded to the

patient within thirty days of achieving the HAP designation.

G. QUALIFIED PROVIDERS: For a list of our current providers, please click here. In some instances services provided by a physician not employed by Mid Valley Hospital or Mid Valley Clinic may provide services for you during your visit at Mid Valley Hospital. Those providers will bill you separately for their services which will not be included in Mid Valley's Health Care Assistance Program. You may contact them directly for their assistance programs.

All revision dates:	09/2021, 05/2021, 11/2020, 10/2019, 10/2019, 03/2018, 04/2016, 01/2016, 05/2012, 04/2011, 05/2009, 01/2008

Attachments

HAP-2021.pdf

Approval Signatures

Approver	Date
Randy Coffell: HR Director/Safety/Education	09/2021
Holly Stanley: CFO	08/2021
Jerri Dion: Director of Revenue Cycle	08/2021

Mid-Valley Hospital
PO Box 793 - Omak, WA. 98841 www.mvhealth.org
Mid-Valley Hospital
Mid-Valley Clinic
509.826.1760

Notice of Availability of Healthcare Assistance Program - Effective February 1, 2022

Patient eligibility for the Healthcare Assistance Program is determined by measuring family income against the federal poverty guidelines. The current income guidelines are as follows:

Sliding Payment Scale
based on
Monthly Income

Family Size	Patient Pays 0% Monthly Income	Patient Pays 24% Monthly Income	Patient Pays 48% Monthly Income	Patient Pays 55% Monthly Income	Patient Pays 63% Monthly Income	Patient Pays 100% Monthly Income Over
1	0 to 1,133	1,134 to 1,699	1,700 to 2,265	2,266 to 2,831	2,832 to 3,398	3,399
2	0 to 1,526	1,527 to 2,289	2,290 to 3,052	3,053 to 3,815	3,816 to 4,578	4,579
3	0 to 1,919	1,920 to 2,879	2,880 to 3,838	3,839 to 4,798	4,799 to 5,758	5,759
4	0 to 2,313	2,314 to 3,469	3,470 to 4,625	4,626 to 5,781	5,782 to 6,938	6,939
5	0 to 2,706	2,707 to 4,059	4,060 to 5,412	5,413 to 6,765	6,766 to 8,118	8,119
6	0 to 3,099	3,100 to 4,649	4,650 to 6,198	6,199 to 7,748	7,749 to 9,298	9,299
7	0 to 3,493	3,494 to 5,239	5,240 to 6,985	6,986 to 8,731	8,732 to 10,478	10,479
8	0 to 3,886	3,887 to 5,829	5,830 to 7,772	7,773 to 9,715	9,716 to 11,658	11,659

For family units with more than eight (8) members, add $393.33 per month for each additional member.

If you think you are eligible for the Healthcare Assistance Program and wish to request it, please make a written request to the Business Office. The Business Office will make a written determination of eligibility within fourteen (14) business days of your request, provided you have supplied the proper documentation.

Mid-Valley Hospital & Clinic

PO Box 793, Omak, WA 98841
(509) 861-2520
mvhealth.org

Healthcare Assistance Program Application Form Instructions

This is an application for financial assistance (also known as charity care) at Mid Valley Hospital / Mid Valley Medical Group.

Washington State requires all hospitals to provide financial assistance to people and families 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. Reference Mid Valley Hospital's Healthcare Assistance Program Policy regarding eligibility and sliding fee scale.

What does financial assistance cover? The hospital financial assistance covers appropriate hospital-based services provided by Mid Valley Hospital / Mid Valley Medical Group depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

If you have questions or need help completing this application: Contact the Patient Accounts office at 509-861-2440 or 509-826-7647. You may obtain help for any reason, including disability and language assistance.

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

- □ **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)
- □ **Provide us information about your family's gross monthly income (income before taxes and deductions)**
- □ **Provide documentation for family income**
- □ **Attach additional information if needed**
- □ **Sign and date the form**

Mail or fax completed application with all documentation to:
Mid Valley Hospital, Patient Accounts Department
PO Box 793
Omak, WA 98841
Fax: 509-826-7631

To submit your completed application in person:
Mid Valley Hospital, Patient Accounts Department
810 Jasmine Street
Omak, WA 98841
8:00 am – 4:30 pm Monday through Friday

Be sure to keep a copy for your records.

We will notify you of the final determination of eligibility and appeal rights, if applicable, 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 application within 14 days!
You may receive bills until we receive your information.

Mid-Valley Hospital & Clinic

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Healthcare Assistance Program Application Form Instructions

-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**
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
□ Male □ Female □ Other (may specify _____)	Birth Date		
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	
Mailing Address _____ _____ City State Zip Code			Main contact 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** (_____)			

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*_____)

Mid-Valley Hospital & Clinic

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mvhealth.org

Healthcare Assistance Program Application Form Instructions
-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.

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, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that Mid Valley Hospital / Mid Valley Medical Group 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

Mid-Valley Hospital & Clinic

PO Box 793, Omak, WA 98841
(509) 861-2520
mvhealth.org

Instrucciones del formulario de solicitud de asistencia financiera/atención benéfica

Esta es una solicitud de asistencia financiera (también conocida como atención benéfica) en Mid-Valley Hospital / Mid-Valley Medical Group.

El estado de Washington requiere que todos los hospitales proporcionen asistencia financiera a las personas y familias que cumplan con ciertos requisitos de ingresos. Usted podría calificar para obtener atención gratuita o a precio reducido en función del tamaño y los ingresos de su familia, inclusive si tiene seguro de salud. Referente a la póliza de Mid-Valley Hospital Healthcare Assistance Program sobre elegibilidad y escala de tarifas ajustables.

¿Qué cubre la asistencia financiera? La asistencia financiera hospitalaria cubre los servicios hospitalarios pertinentes proporcionados por Mid-Valley Hospital / Mid-Valley Medical Group dependiendo de su elegibilidad. La asistencia financiera podría no cubrir todos los costos de la atención médica, incluso los servicios suministrados por otras organizaciones.

Si tiene preguntas o necesita ayuda para completar esta solicitud: Comuníquese con Patient Accounts Department (Departamento de Contabilidad del Paciente) llamando al (509) 861-2440 o (509) 826-7647. Puede obtener ayuda por cualquier motivo, inclusive asistencia por discapacidad y con el idioma.

A fin de que se procese su solicitud, usted debe:

- □ **Proporcionarnos información sobre su familia**
  Complete la cantidad de miembros que integran su familia (la familia incluye a las personas emparentadas por vínculo biológico, matrimonio u adopción que vivan juntas)
- □ **Proporcionarnos información sobre los ingresos mensuales brutos de su familia (ingresos antes de impuestos y deducciones)**
- □ **Proporcionar documentación de los ingresos familiares**
- □ **Adjuntar información adicional de ser necesario**
- □ **Firmar y fechar el formulario**

Envíe la solicitud completada por correo postal o por fax con toda la documentación a:	Mid-Valley Hospital, Patient Accounts Department PO Box 793, Omak Washington 98841 Fax: (509) 826-7631
Para presentar su solicitud completada personalmente:	Mid-Valley Hospital, Patient Accounts Department 810 Jasmine Street, Omak Washington 98841 8:00am – 4:30pm Fax: (509) 826-7631

Asegúrese de conservar una copia para usted.

Le notificaremos la determinación final de elegibilidad y los derechos de apelación, si corresponde, dentro de los 14 días calendario desde que recibamos una solicitud de asistencia financiera completa, incluida la documentación de los ingresos.

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Al presentar una solicitud de asistencia financiera, usted nos da su consentimiento para hacer las averiguaciones necesarias con el fin de confirmar la información y las obligaciones financieras.

Queremos ayudar. ¡Por favor presente su solicitud dentro de los 14 días siguientes! Usted podría recibir facturas hasta que recibamos su información.

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Formulario de solicitud de asistencia financiera/atención benéfica -CONFIDENCIAL

Complete toda la información. Si no corresponde, escriba "NC". Adjunte más hojas de ser necesario.

INFORMACIÓN DE SELECCIÓN

¿Necesita un intérprete? □ **Sí** □ **No** *Si responde Sí, indique el idioma que prefiere:*

¿El paciente ha solicitado Medicaid? □ **Sí** □ **No** *Es posible que deba solicitarlo antes de que pueda ser considerado para la asistencia financiera*

¿Recibe el paciente servicios públicos estatales, como TANF, Basic Food o WIC? □ **Sí** □ **No**

¿Es el paciente actualmente una persona sin hogar? □ **Sí** □ **No**

¿La necesidad de atención médica del paciente está relacionada con un accidente automovilístico o una lesión en el trabajo? □ **Sí** □ **No**

TENGA EN CUENTA LO SIGUIENTE

- No podemos garantizarle que reunirá los requisitos para obtener asistencia financiera, incluso si la solicita.
- Una vez que envíe su solicitud, podremos verificar toda la información y pedirle información adicional o comprobantes de ingresos.
- En el transcurso de 14 días calendario luego de que recibamos su solicitud completada y la documentación, le notificaremos si califica para la asistencia.

INFORMACIÓN DEL PACIENTE Y DEL SOLICITANTE

Primer nombre del solicitante	Segundo nombre del solicitante		Apellido del solicitante
□ Varón □ Mujer □ Otro (puede especificar _____)	Fecha de nacimiento		
Persona responsable de pagar la factura	Relación con el paciente	Fecha de nacimiento	
Dirección postal _____ _____ Ciudad Estado Código postal			Número(s) de contacto principal(es) ( ) _____ ( ) _____ Dirección de correo electrónico: _____

Situación laboral de la persona responsable de pagar la factura
□ **Empleado** (fecha de contratación: _____) □ **Desempleado** (tiempo que lleva desempleado:_____)
□ **Trabajador independiente** □ **Estudiante** □ **Discapacitado** □ **Jubilado** □ **Otro** (_____)

INFORMACIÓN FAMILIAR

Indique los miembros que integran su familia, incluido usted. "Familia" incluye a las personas emparentadas por vínculo biológico, matrimonio u adopción que viven juntas.

TAMAÑO DE LA FAMILIA _____ *Adjunte otra hoja de ser necesario.*

Nombre	Fecha de nacimiento	Relación con el paciente	Si tiene 18 años o más: Nombre del (de los) empleador(es) o fuente de ingresos	Si tiene 18 años o más: Ingresos mensuales totales brutos (antes de impuestos):	¿También solicita asistencia financiera?
					Sí / No
					Sí / No
					Sí / No
					Sí / No

Deben divulgarse los ingresos de todos los miembros de la familia adultos. Las fuentes de ingresos incluyen, por ejemplo:
- Salarios - Desempleo - Trabajo por cuenta propia - Compensación por accidentes de trabajo - Discapacidad
- Seguridad de ingreso suplementario (SSI) - Manutención de menores/conyugal
- Programas de estudio y trabajo (estudiantes) - Pensión - Distribuciones de cuentas de jubilación - Otro (*explicar*_____)

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Formulario de solicitud de asistencia financiera/atención benéfica - CONFIDENCIAL

INFORMACIÓN SOBRE INGRESOS

***RECUERDE**: Debe incluir comprobantes de ingresos con su solicitud.*

Debe proporcionar información sobre los ingresos de su familia. Se requiere la verificación de ingresos para determinar la asistencia financiera.

Todos los miembros de la familia de 18 años o más deben divulgar sus ingresos. Si no puede proporcionar la documentación, puede presentar una declaración por escrito firmada en la que describa sus ingresos. Proporcione el comprobante para cada fuente de ingresos identificada.

Entre los ejemplos de comprobantes de ingresos se incluyen:

- Una declaración de retención "W-2"; o
- Recibos de pago actuales (*mínimo necesario, no más de 3 meses*); o
- Declaración de impuestos sobre los ingresos del año anterior, incluidos los anexos si corresponde; o
- Declaraciones por escrito firmadas de empleadores u otros; o
- Aprobación/denegación de elegibilidad para Medicaid y/o asistencia médica con financiamiento del estado; o
- Aprobación/denegación de elegibilidad para compensación por desempleo.

Si usted no tiene un comprobante de ingresos o no tiene ingresos, adjunte otra hoja con una explicación.

INFORMACIÓN ADICIONAL

Adjunte otra hoja si existe otra información sobre su situación financiera actual que desea que sepamos, como por ejemplo, dificultades económicas, gastos médicos excesivos, ingresos estacionales o temporales, o pérdida personal.

ACEPTACIÓN DEL PACIENTE

Entiendo que Mid-Valley Hospital / Mid-Valley Medical Group puede verificar la información revisando la información de crédito y obteniendo información de otras fuentes para poder determinar la elegibilidad para la asistencia financiera o los planes de pago.

Ratifico que la información anterior es verdadera y correcta a mi leal saber y entender. Entiendo que si se determina que la información financiera que yo proporciono es falsa, esto podría dar como resultado que se me negara la asistencia financiera, y yo podría ser responsable y tener que pagar por los servicios proporcionados.

_____ _____

Firma de la persona que presenta la solicitud Fecha