Date Given: _______
Due by: _______

Financial Assistance Application

Kootenai Health, Kootenai Clinics, Kootenai Heart Clinics Northwest, Kootenai Imaging and Western Medical Association

We understand that unexpected medical debt can be a financial hardship and we are committed to assist you with your financial obligation. **This application needs to be completed within 21 days and returned to one of the following locations:**

Mailed to:
Clearwater Valley Hospital/Clinics
301 Cedar
Orofino, ID 83544

OR

Mailed to:
St. Mary's Hospital/Clinics
PO Box 137
701Lewiston St.
Cottonwood, ID 83522

OR you can drop it off at either hospital or clinics.

In order to process your application, the following information (if applicable) is required for **ALL MEMBERS OF THE HOUSEHOLD:** (this includes individuals residing together who have consented to an arrangement similar to the ties of blood or marriage).

Do not send originals and please no staples

- Current, Valid Picture I.D.
- The patient's most recent filed Federal Tax Return with **all** schedules. If unable to provide the tax return, alternate documents may be substituted: Supporting W-2's **and/or** or 1099 statements and a broker's statement from the IRS.
- Current **three** months of employer pay stubs
- **All** pages of **all** checking, savings and other bank statements for last **three** months
- Social security benefit documentation
- Disability and/or Unemployment benefits documentation
- Current food stamps award letter from patient's state of residence
- Written documentation from any other income sources, to include assistance received from an individual or organization
- Proof of mortgage, rent and utilities payment
- Proof of Assets, to include supporting documentation of:
  *Value of home (if owned) *Stocks and bonds
  *Vehicles *Life insurance with cash value
  *Assets available through a family or other Trust

Please contact Financial Services Counseling at 208-476-4555 or 208-962-3251 if you have any questions. CVHC Fax 208-476-5385, SMH Fax 208-962-2478.

**We use the Federal Poverty Guidelines when determining eligibility*

KootenaiHealth

Date Given: ________
Due by: ________

Medical bills you wish to be considered for assistance:

Provider Name	Date of Service	Account Number	Amount Owed

Comments ____

____

____

____

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____

Revised: 10/2019

Financial Assistance Application

Date Financial Counselor Received

____

Patient/Applicant

First Name/Parent ____________________ Middle ___ Last Name ________________ Date of Birth __________

Address ________________________________ City ___________________ State ________ Zip _________

Daytime Phone ___________________ **LIVING ARRANGEMENT**: Rent ___ Own___ Other _______________

Spouse/Significant Other ______________________ Date of Birth _________ Daytime Phone _____________

Number of children under the age of 18 ____ Is Patient a minor? □ Yes □ No If Yes, name of Minor______________

Is this a result of a

Vehicle accident? □ Yes □ No Work injury? □ Yes □ No Result of a crime? □ Yes □ No

Is the patient a Veteran? □ Yes □ No Is the patient pregnant? □ Yes □ No

Gross Monthly Income

Self_________ Spouse/Significant Other __________ Unemployment _________ Food Stamps ___________

Social Security / SSI/ SSD _______ Loans / Gifts______ Worker's Comp _________ Inheritance / Trust _______

Veteran's Benefits _________ Child Support _______ Pension / Retirement ______ Other _______________

TOTAL Gross Income $________________

Monthly Expenses

Rent/Mortgage	____________	Telephone	____________	Auto Insurance	__________
2nd Mortgage	____________	Prescriptions	____________	Car Payment	__________
Space Rent	____________	Gasoline / Fuel	____________	Home / Rent Ins.	__________
Food	____________	Child Care	____________	Garnishments	__________
Electricity/Heat	____________	Doctor / Hospital	____________	Life Insurance	__________
Water/Sewer/Trash	____________	Child Support	____________	Health / Accident Ins.	__________

TOTAL Monthly Expenses $______________

ASSETS

All Business & Personal Bank Accounts:

Checking Account - Bank Name ________________________ Current Balance ____________________

Checking Account - Bank Name ________________________ Current Balance ____________________

Savings Account – Bank Name ________________________ Current Balance ____________________

Savings Account – Bank Name ________________________ Current Balance ____________________

Stocks, CD's, Trusts __________________________________ Current Balance ____________________

401K, Retirement, IRAs ______________________________ Current Balance ____________________

Life Insurance Cash Value _______________ Other Assets ________________ Value ________________

Home/ Properties ______________________ ________________ ______________________

Value Purchase Date Amount Owed

Land / Rental Properties ____________________ ________________ ______________________

Value Purchase Date Amount Owed

Vehicle _____ ________________ ____________ ______________ ________________

Year Make Current Value Amount Owed Monthly Payment

Vehicle _____ ________________ ____________ ______________ ________________

Year Make Current Value Amount Owed Monthly Payment

Vehicle _____ ________________ ____________ ______________ ________________

Year Make Current Value Amount Owed Monthly Payment

Recreational (Boat, RV, ATV, MC) _____ _____________ ____________ ___________ ___________

Year Type Current Value Amount Owed Payment

Recreational (Boat, RV, ATV, MC) _____ _____________ ____________ ___________ ___________

Year Type Current Value Amount Owed Payment

I authorize Kootenai Health to verify the information that I have supplied on this statement to be true and to access credit information if needed.

____ ___________________________

Signature Date

Revised: 9/2019