Financial Assistance Application

St. Mary's Health/Clearwater Valley Health

Received: _____

Due by: _____

We understand that unexpected medical debt can be a financial hardship, and we are committed to assisting you with your financial obligation. **This application needs to be completed within 30 days and returned to one of the following locations:**

In person or mailed to:

St. Mary's Health
701 Lewiston St
Cottonwood Idaho,83522

Clearwater Valley Health
301 Cedar
Orofino Idaho, 83544

To process your application, the following information (if applicable) is required for **All members of the household**. Please do not use staples or send originals.

- Current and valid photo ID
- The patient's most recent filed Federal Tax Return or two alternative substitutes, to include a current W-2 or 1099, your most recent bank statement, 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)
  - ✓ Vehicles
  - ✓ Stocks and bonds
  - ✓ Life insurance with cash value
  - ✓ Assets available through a family or other Trust

Please call St. Mary's Health or Clearwater Valley Health Financial Counseling at 208-962-7522 if you have any questions or email us at FinancialCounselingSMCVH@kh.org.

We use the Federal Poverty Guidelines when determining eligibility.

Financial Assistance Application

Date Financial Counselor Received

Patient/Applicant:

Name/Parent

First: _____Middle: _____Last: _____

Date of birth: __/___/_____

Address: _____City: _____State: ____ Zip: _____

Daytime phone: ( ) _____Email: _____

Living arrangement: ❑ Rent ❑ Own ❑ Other: _____

Spouse/significant other name: _____

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 the result of a: Vehicle accident ❑ Yes ❑ No work injury ❑ Yes ❑ No Crime ❑ Yes ❑ No

Is the patient: A veteran ❑ Yes ❑ No Pregnant ❑ Yes ❑ No

Household Gross Monthly Income

Self: _____Spouse/significant other: _____Unemployment: _____

Food stamps: _____Social Security/SSI/SSD: _____Loans/gifts: _____

Worker's compensation: _____Inheritance/trust: _____Veteran's benefits: _____

Child support: _____Pension/retirement: _____Other: _____

Total Gross Income: _____

Household Monthly Expenses (not listed on pay stub)

All rent/mortgage: _____All insurance (Auto, home, and health): _____

Prescriptions: _____Car payment: _____Space rent: _____Gas/fuel: _____

Home/rental insurance: _____Food/groceries: _____Childcare: _____

Garnishments: _____Child support: _____

Total utilities (Electricity, water, and sewer: _____Doctor/hospital bills: _____

Total Monthly Expenses: _____

St. Mary's Health//Clearwater Valley Health reserves the right to request additional information to determine eligibility for financial assistance.

Assets

All business and personal bank accounts (please use additional sheet if needed)

Checking account #: _____ Bank/financial institution: _____ Current balance: _____

Checking account #: _____ Bank/financial institution: _____ Current balance: _____

Savings account #: _____ Bank/financial institution: _____ Current balance: _____

Savings account #: _____ Bank/financial institution: _____ Current balance: _____

Stocks, CDs, or trusts: _____ Current balance: _____

401(k), 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 | Purchase Date | Amount owed | Monthly payment

Vehicle: _____ _____ _____ _____ _____

Year | Make | Purchase Date | Amount owed | Monthly payment

Recreational (Boat, RV, ATV, MC): _____ _____ _____ _____ _____

Year | Make | Purchase date | Amount owed | Monthly payment

Recreational (Boat, RV, ATV, MC): _____ _____ _____ _____ _____

Year | Make | Purchase date | Amount owed | Monthly payment

I authorize St. Mary's/Clearwater Valley Health to verify the information that I have supplied on this statement to be true and to access credit information if needed.

_____ _____

Signature | Date

If you are not approved for financial assistance, you will be required to set up a payment plan for any remaining balance.