Kindred Hospitals

Kindred Hospital Seattle- First Hill

Charity Care/Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as charity care) at Kindred Hospital Seattle-First Hill ("Hospital").

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.

Charity Care is generally secondary to all other financial resources available to the patient, including the following: group or individual medical plans; Workers' Compensation; Medicare; Medicaid or medical assistance programs; other state, Federal, or military programs; any other Third Party (e.g. auto accidents or personal injuries); or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical services.

In those situations where appropriate primary payment sources are not available, for medically necessary hospital care received on or after June 9, 2022, Hospital will consider patients for Financial Assistance and Charity Care under this policy, when Third-Party Coverage, if any, has been exhausted, based on the following criteria:

Income as a Percentage of Federal Poverty Level	**Percentage Discount**
Less than or equal to 200 percent	100 percent
201-250 percent	75 percent
251-300 percent	50 percent

1. The full amount of patient or guarantor responsibility for hospital charges will be determined to be Charity Care for a patient or their guarantor whose income is at or below 200% of the current federal poverty level, adjusted for family size. Hospital will not consider the value of assets to reduce Charity Care discounts for individuals in this category.

2. Seventy-five percent of patient or guarantor responsibility for hospital charges will be determined to be Charity Care for a patient or their guarantor whose income is between 201% and 250% of the current federal poverty level, adjusted for family size, which percentage discount may be reduced by amounts reasonably related to assets considered as set forth in this application.

3. Fifty percent of uncovered hospital charges will be determined to be Charity Care for a patient or their guarantor whose income is between 251% and 300% of the current federal poverty level, adjusted for family size, which percentage discount may be reduced by amounts reasonably related to assets considered as set forth in this application.

Catastrophic Charity: The Hospital may write off as Charity Care amounts for patients with family income in excess of 300 percent of the Federal Poverty Level when circumstance indicate severe financial hardship or personal loss.

The patient's or the patient's guarantor's financial obligation which remains after the application of any Charity Care or Financial Assistance schedule shall be payable as negotiated between the Hospital and the responsible party. The responsible party's account shall not be turned over to a collection agency unless payments are missed or there is some period of inactivity on the account, and there is no satisfactory contact with the patient.

Hospital will not require a disclosure of assets from Charity Care applicants whose income is less than 200 percent of the current Federal Poverty Level but may require a disclosure of resources from Charity Care applicants whose income is at or above 201 percent of the current Federal Poverty Level.

What does financial assistance cover? The hospital financial assistance covers appropriate hospital-based services provided by ***Kindred Hospital Seattle- First Hill*** 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: Central Admissions Department which can be contacted at **(702) 720-3053, Option #2** 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 and declare assets**
- □ **Attach additional information if needed**
- □ **Sign and date the form**

Note: **You do not have to provide a Social Security number to apply for financial assistance**. If you provide us with your Social Security number it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

Mail or fax completed application with all documentation to: *Kindred Hospital Seattle- First Hill*
1334 Terry Avenue Seattle, WA 98101; Attn: Administration. Be sure to keep a copy for yourself.

To submit your completed application in person: a Patient Relations Representative at 1334 Terry Avenue, Seattle, WA 98101

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 promptly!
You may receive bills until we receive your information.

Kindred Hospital Seattle- First Hill

Charity Care/Financial Assistance Application Form – 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** *May be required to apply before being considered for financial assistance*
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		Patient Social Security Number (optional*) **optional, but needed for more generous assistance above state law requirements*
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional*) **optional, but needed for more generous assistance above state law requirements*
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*_____)

Kindred Hospital Seattle- First Hill

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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. <u>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.</u>

<u>Examples of proof of income include:</u>

- 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.

EXPENSE INFORMATION

We use this information to get a more complete picture of your financial situation.

<u>Monthly Household Expenses:</u>

Rent/mortgage $_____

Insurance Premiums $_____

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

Medical expenses $_____

Utilities $_____

ASSET INFORMATION

This information may be used if your income is above 200% of the Federal Poverty Guidelines.

Current checking account balance
$_____

Current savings account balance
$_____

Does your family have these other assets?
<u>Please check all that apply</u>
□ Stocks □ Bonds □ 401K □ Health Savings Account(s) □ Trust(s)
□ Property (excluding primary residence) □ Own a business

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 ***Kindred Hospital Seattle- First Hill*** 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