Appendix C

Lake Health District

700 South J Street, Lakeview, OR 97630
(541) 947-2114

FINANCIAL ASSISTANCE APPLICATION

Completion of Application

a.) The Financial Assistance Application may be printed from the Lake Health District website or received from the Patient Services Office. Applications may be requested via mail.

b.) The completed application is required to be submitted within 120 days of initial statement. Incomplete applications will be returned with request of additional information. To continue application process additional information must be received within 30 days. If completed application is not received within 120 days of initial statement financial assistance will be denied and normal collection process will continue.

c.) Lake Health District will make determination on applications within 30 days of receipt of completed application. Determination letters will be sent via mail.

d.) All information relating to the application for financial assistance will be kept confidential.

Eligibility Criteria

a.) Income Level Requirement

Patient eligibility for financial assistance is determined by measuring household income against the income poverty guidelines established by the U.S. Department of Health and Human Services. A sliding fee scale will be used to determine financial assistance discounts when household income is at or below 400% of federal income poverty guidelines. Patients will be held responsible to pay balances based on this determination.

b.) Determination

I. Considerations for assistance include a review of responsible parties' annual household income based on previous year's tax returns and other verifiable proof of income (pay stubs, bank statements…). Federal guidelines also consider number of people living in household.

II. Employment status should consider the likelihood of future earnings sufficient to meet the healthcare related obligation within a reasonable amount of time. Other financial obligations may be considered.

III. The need for financial assistance will be re-evaluated at each subsequent time of service if the last financial evaluation was completed more than one year prior to the date of service, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known.

IV. The District may require patients to verify that they have first applied for assistance with a State assistance agency (such as, State Health Plan, SSI or SSD) and have been denied.

V. Financial assistance awards will be made after any pending eligibility determinations have been made by another payer source.

VI. Determination for assistance is based on applicant's current financial situation.

VII. Eligibility for Financial Assistance is not restricted because of race, religion, sex, national origin, age, handicap, or sexual orientation.

VIII. Financial assistance is available for medically necessary services only.

_____ _____

Guarantor Signature Date

*FA Application and guidelines are available in Spanish upon request

Lake Health District
Quality Care Close to Home

Lake Health District

700 South J Street, Lakeview, OR 97630
(541)947-2114

Guarantor's Information:

Guarantor's Name: Last, First, MI					Social Security Number
Date of Birth	Account Number	Employer: Name, Address, Telephone			
Street Address	City	State	Zip Code	Telephone	
Mailing Address (If Different Than Above)	City	State	Zip Code	Marital Status ☐Married ☐Divorced ☐Single	

Household Information: Please indicate ALL people living in your household, including applicant

Please list anyone living in your household (including yourself). Income includes gross wages, salaries, tips, self-employment income, child support, alimony, rental income, unemployment compensation, social security benefits, public/government assistance, etc. (Income also includes rent or living expenses exchanged for services provided.)

Household Members	Date of Birth	Relationship	Source of Income and/or Employer	Gross Annual Income
1.				$
2.				$
3.				$
4.				$
5.				$
6.				$

Federal Income Poverty Level 2021	100%	125%	150%	175%	200%	250%	275%	300%	325%	350%	375%	400%
% of Discount	100%	100%	100%	100%	100%	95%	85%	75%	65%	55%	45%	25%
Patient Maximum Responsibility Plus Discounted Percentage	$0	$0	$0	$500	$1,000	$2,000	$4,000	$8,000	$16,000	$16,000	$16,000	$16,000
1	12,760	15,950	19,140	22,330	25,520	31,900	35,090	38,280	41,470	44,660	47,850	51,040
2	17,240	21,220	25,530	29,840	34,150	42,770	47,080	51,390	55,700	60,010	64,320	68,630
3	21,720	27,150	32,580	38,010	43,440	54,300	59,730	65,160	70,590	76,020	81,450	86,880
4	26,200	32,750	39,300	45,850	52,400	65,500	72,050	78,600	85,150	91,700	98,250	104,800
5	30,680	38,350	46,020	53,690	61,360	76,700	84,370	92,040	99,710	107,380	115,050	122,720
6	35,160	43,950	52,740	61,530	70,320	87,900	96,690	105,480	114,270	123,060	131,850	140,640
7	39,640	49,550	59,460	69,370	79,280	99,100	109,010	118,920	128,830	138,740	148,650	158,560
8	44,120	55,150	66,180	77,210	88,240	110,300	121,330	132,360	143,390	154,420	165,450	176,480

I agree to pay $_____ per month against the medical bills incurred at Lake Health District, however I understand that the payment required will be determined by Lake Health District.
I certify the above information is true and correct to the best of my knowledge. I understand that the information which I submit is subject to verification and hereby authorize any party contacted by Lake Health District to release the requested verification to the Health District.

_____ _____
Guarantor Signature Date

This institution is an equal opportunity employer and provider