



Lake Health District

700 South J Street, Lakeview, OR 97630

(541)947-2114

FINANCIAL ASSISTANCE APPLICATION

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 <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> 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, retirement compensation etc.

*Income also includes rent or living expenses exchanged for services provided.

** VA Disability Compensation is not included as income

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 2022	Base Line	< 200%	200% - 300%	300% - 350%	350% - 400%
% Discount	100%	100%	75%	50%	25%
Persons in family / household	Annual Income				
1	\$13,590	\$27,180	\$27,180 - \$40,770	\$40,770 - \$47,565	\$47,565 - \$54,360
2	\$18,310	\$36,620	\$36,620 - \$54,930	\$54,930 - \$64,085	\$64,085 - \$73,240
3	\$23,030	\$46,060	\$46,060 - \$69,090	\$69,090 - \$80,605	\$80,605 - \$92,120
4	\$27,750	\$55,500	\$55,500 - \$83,250	\$83,250 - \$97,125	\$97,125 - \$111,000
5	\$32,470	\$64,940	\$64,940 - \$97,410	\$97,410 - \$113,645	\$113,645 - \$129,880
6	\$37,190	\$74,380	\$74,380 - \$111,570	\$111,570 - \$130,165	\$130,165 - \$148,760
7	\$41,910	\$83,820	\$83,820 - \$125,730	\$125,730 - \$146,685	\$146,685 - \$167,640
8	\$46,630	\$93,260	\$93,260 - \$139,890	\$139,890 - \$163,205	\$163,205 - \$186,520
For families/households with more than 8 persons, add \$4,720 to baseline income for each additional person.					

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