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 ☐ 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, 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	$27,1800	$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 thepayment 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