Lake Health Clinic

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

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS/QUALIFICATIONS

Completion of Application

- The Financial Assistance Application may be printed from the Lake Health Clinic website or received from the Patient Services Office. Applications may be requested via mail.
- The completed application is required to be submitted within 240 days of reception of the initial billing statement. Incomplete applications will be returned with a request for additional information. To continue the application process additional information must be received within 30 days. If the completed application is not received within 240 days of the initial statement financial assistance will be denied and the normal collection process will continue.
- Lake Health Clinic will make determination on applications within 30 days of receipt of completed application. Determination letters will be sent via mail.
- All information relating to the application for financial assistance will be kept confidential.

Eligibility Criteria and Amounts Charged to Patients

1. Discounts will be made available to eligible patients on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of determination. Once a patient has been determined by LHD to be eligible for financial assistance, that patient shall not receive any future bills based on undiscounted gross charges. The basis for the amounts LHD will charge patients qualifying for financial assistance is as follows:
   - Patients whose family income is at or below 200% of the FPL are eligible to receive full financial assistance (free care);
   - Patients whose family income is above 200% but not more than 400% of the FPL are eligible to receive services discounted on a sliding fee schedule. Discounts will be applied to the patient's cost. Services will be discounted to an amount no greater than the amounts generally received by LHD for Medicare patients (the Amounts Generally Billed, AGB). No patients eligible for Financial Assistance will be billed more than the AGB amount.
   - Veterans Disability Benefits are not included as income under the financial aid application due to their nontaxable status under the Federal Government
   - See Appendix A for the FPL Chart
2. Determination
   A. 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, etc.). Federal guidelines also consider the number of people living in a household, not the number of dependents.
   B. 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.
   C. 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.
   D. The Clinic 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.
   E. Financial assistance awards will be made after any pending eligibility determinations have been made by another payer source.
   F. Determination for assistance is based on applicant's current financial situation.
   G. Eligibility for Financial Assistance is not restricted because of race, religion, sex, national origin, age, handicap, or sexual orientation.
   H. Financial assistance is available for medically necessary services only.

_____ _____

Guarantor Signature Date

FA Application and guidelines are available in Spanish upon request

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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 2023	Base Line	< 200%	200% - 300%	300% - 350%	350% - 400
Discount %	100%	100%	75%	50%	25%
Persons in family / household	Annual Income				
1	$14,580	$29,160	$29,161 - $43,740	$43,741 - $51,030	$51,031 - $58,320
2	$19,720	$39,440	$39,441 - $59,160	$59,161 - $69,020	$69,021- $78,880
3	$24,860	$49,720	$49,721 - $74,580	$74,581 - $87,010	$87,011 - $99,440
4	$30,000	$60,000	$60,001 - $90,000	$90,001 - $105,000	$105,001 - $120,000
5	$35,140	$70,280	$70,281 - $105,420	$105,421- $122,990	$122,991 - $140,560
6	$40,280	$80,560	$80,561 - $120,840	$120,841 - $140,980	$140,981- $161,120
7	$45,420	$90,840	$90,841 - $136,260	$136,261 - $158,970	$158,971 - $181,680
8	$50,560	$101,120	$101,121 - $151,680	$151,681 - $176,960	$176,961 - $202,240
For families/households with more than 8 persons, add $5,140 for each additional person.					

Information retrieved from: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

I agree to pay $_____per month against the medical bills incurred at Lake Health Clinic, however I understand that the payment required will be determined by Lake Health Clinic.
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 Clinic to release the requested verification to the Health Clinic.

_____ _____
Guarantor Signature Date

This institution is an equal opportunity employer and provider