Lake Health District

700 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 District 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 District 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**
   Eligibility for Financial Assistance will be determined in accordance with procedures that involve an individual assessment of financial need. Each patient or the patient's guarantor is required to cooperate and provide personal, financial, and other documentation relevant to making a determination of financial need.
   A. Financial assistance is available for medically necessary services only.
   B. Eligibility for Financial Assistance is not restricted because of race, religion, sex, national origin, age, handicap, or sexual orientation.
   C. Make reasonable efforts to explore appropriate sources of payment and coverage from public and private programs and assist patients in applying for such programs.
   D. Financial assistance awards will be made after any pending eligibility determinations have been made by another payer source.
   E. Determination for assistance is based on the applicant's current financial situation.
   F. Take into account all of the patients financial resources.
   G. Conduct a review of the patients' outstanding accounts receivable for prior services rendered and the patients payment history.
   H. 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, etc.). Federal guidelines also consider the number of people living in a household, not the number of dependents.
   I. 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.
   J. 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.

What If I Have Questions or Need Help Filling Out the Application?

If you have questions or need help filling out the Financial Assistance Application, you can contact the LDH Business Office: Phone: (541) 947-2114. In Person: LDH Business Office, 700 South J St., Lakeview, OR 97630.
Submit your application by mailing or In Person: LDH Business Office, 700 South J St., Lakeview, OR 97630
Email your application to: #ptsvcs@lakehealthdistrict.org

_____ _____

Guarantor Signature Date

FA Application and guidelines are available in Spanish upon request

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					
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	

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 2026	Base Line	< 200%	200% - 300%	300% - 350%	351% - 400
Discount %	100%	100%	75%	50%	25%
Persons in family / household	Annual Income				
1	$15,960	$31,920	$31,921 - $47,880	$47,881 - $55,860	$ 55,861 - $63,840
2	$21,640	$43,280	$43,281 - $64,920	$64,921 - $75,740	$ 75,741 - $86,560
3	$27,320	$54,640	$54,641 - $81,960	$81,961 - $95,620	$ 95,621 - $109,280
4	$33,000	$66,000	$66,001 - $99,000	$99,001 - $115,500	$115,501 - $132,000
5	$38,680	$77,360	$77,361 - $116,040	$116,041 - $135,380	$135,380- $154,720
6	$44,360	$88,720	$88,721 - $133,080	$133,080 - $155,260	$155,260- $177,440
7	$50,040	$100,080	$100,081 - $150,120	$150,121 - $175,140	$175,141 - $200,160
8	$55,720	$111,440	$111,441 - $167,160	$167,161 - $195,020	$195,021 - $222,880
For families/households with more than 8 persons, add $5,680 for each additional person.					

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

I agree to pay the agreed-upon amount as indicated in the Patient Payment Plan, for the medical bills incurred at Lake Health District. I further understand that the Lake Health District will determine the payment required.

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 _____