Financial Assistance Application

Kootenai Health • Kootenai Clinics • Kootenai Outpatient Imaging

Received: _____

Due by: _____

We understand that unexpected medical debt can be a financial hardship and we are committed to assist you with your financial obligation. **This application needs to be completed within 30 days and returned to one of the following locations:**

In person at:
2003 Kootenai Health Way
Coeur d'Alene, ID 83814
(North Entrance Hospital Lobby)

OR

Mailed to:
Kootenai Health Business Services
2003 Kootenai Health Way
Coeur d'Alene, ID 83814

In order to process your application, the following information (if applicable) is required for **All members of the household**. Please do not use staples or send originals.

- Current and valid photo ID
- The patient's most recent filed Federal Tax Return or two alternative substitutes, to include a current W-2 or 1099, your most recent bank statement, a broker's statement from the IRS, and a current credit report
- Current three months of employer pay stubs
- All pages of all checking, savings and other bank statements for last three months
- Social security benefit documentation
- Disability and/or unemployment benefits documentation
- Current food stamps award letter from patient's state of residence
- Written documentation from any other income sources, to include assistance received from an individual or organization
- Proof of mortgage, rent and utilities payment
- Proof of Assets, to include supporting documentation of:
  - ✓ Value of home (if owned)
  - ✓ Vehicles
  - ✓ Stocks and bonds
  - ✓ Life insurance with cash value
  - ✓ Assets available through a family or other Trust

Please call Kootenai Health Financial Counseling at (208) 625-5000 (option 3) if you have any questions.

(We use the Federal Poverty Guidelines when determining eligibility.)

Financial Assistance Application

Date Financial Counselor Received

Patient/Applicant:

Name/Parent

First: _____ Middle: _____ Last: _____

Date of birth: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Daytime phone: ( ) _____ Email: _____

Living arrangement: ❑ Rent ❑ Own ❑ Other: _____

Spouse/significant other name: _____

Date of birth: _____/_____/_____ Daytime phone: ( ) _____

Number of children under the age of 18 _____

Is Patient a minor? ❑ Yes ❑ No If yes, name of minor: _____

Is this the result of a: Vehicle accident ❑ Yes ❑ No Work injury ❑ Yes ❑ No Crime ❑ Yes ❑ No

Is the patient: A veteran ❑ Yes ❑ No Pregnant ❑ Yes ❑ No

Household Gross Monthly Income

Self: _____ Spouse/significant other: _____ Unemployment: _____

Food stamps: _____ Social Security/SSI/SSD: _____ Loans/gifts: _____

Worker's compensation: _____ Inheritance/trust: _____ Veteran's benefits: _____

Child support: _____ Pension/retirement: _____ Other: _____

Total Gross Income: _____

Household Monthly Expenses (not listed on pay stub)

All rent/mortgage: _____ All insurance (Auto, home and health): _____

Prescriptions: _____ Car payment: _____ Space rent: _____ Gas/fuel: _____

Home/rental insurance: _____ Food/groceries: _____ Child care: _____

Garnishments: _____ Child support: _____

Total utilities (Electricity, water and sewer: _____ Doctor/hospital bills: _____

Total Monthly Expenses: _____

Kootenai reserves the right to request additional information to determine eligibility for financial assistance.

Assets

All business and personal bank accounts (please use additional sheet if needed)

Checking account #: _____ Bank/financial institution: _____ Current balance: _____

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Savings account #: _____ Bank/financial institution: _____ Current balance: _____

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Stocks, CDs or trusts: _____ Current balance: _____

401(k), retirement, IRAs: _____ Current balance: _____

Life insurance cash value: _____ Other assets: _____ Value: _____

Home/properties: _____ _____ _____

Value | Purchase date | Amount owed

Land/rental properties: _____ _____ _____

Value | Purchase date | Amount owed

Vehicle: _____ _____ _____ _____ _____

Year | Make | Purchase date | Amount owed | Monthly payment

Vehicle: _____ _____ _____ _____ _____

Year | Make | Purchase date | Amount owed | Monthly payment

Recreational (Boat, RV, ATV, MC): _____ _____ _____ _____ _____

Year | Make | Purchase date | Amount owed | Monthly payment

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Year | Make | Purchase date | Amount owed | Monthly payment

I authorize Kootenai Health to verify the information that I have supplied on this statement to be true and to access credit information if needed.

_____ _____

Signature | Date

If you are approved for financial assistance, you will be required to set up a payment plan for any remaining balance.