

Financial Assistance Application

Kootenai Health • Kootenai Clinic • 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 by one of the following locations:**

In person at:

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

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.)



KootenaiHealth

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

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

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.

