

Financial Assistance Application

Kootenai Health • Kootenai Clinic • Kootenai Outpatient Imaging



KootenaiHealth

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

Online: MyChart Patient Portal

mychart.kh.org

To ensure timely and accurate processing, applicants must provide documentation for all **household members**, as applicable.

Important: Do not submit original documents. Please avoid using staples.

- Government-issued, valid photo identification
- Most recent federal income tax return or two alternative forms of income verification (e.g., W-2, 1099, IRS transcript, recent bank statement, or credit report)
- Pay stubs covering the most recent three (3) months
- Complete bank statements (all pages) for all accounts covering the most recent three (3) months
- Social Security benefit statements (if applicable)
- Current Supplemental Nutrition Assistance Program (SNAP) or equivalent state assistance award letter (if applicable)
- Documentation of all additional income sources, including financial support from individuals or organizations
- Proof of housing expenses, including mortgage or rent, and utility obligations
- Verification of assets, including but not limited to:
 - Real property (primary residence or other owned property)
 - Vehicles
 - Investment accounts (stocks, bonds, etc.)
 - Life insurance policies with cash value
 - Trust assets or other accessible financial resources

I hereby certify that the information provided in this application and supporting documentation is true, complete, and accurate to the best of my knowledge.

I authorize Kootenai Health to verify all information provided, including but not limited to employment, income, assets, and credit information, as necessary to determine eligibility for financial assistance.

I understand that submission of incomplete or inaccurate information may result in delays or denial of assistance.

Guarantor Signature

Guarantor Print Name

Date: _____

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.)