www.mvhealth.org
Mid-Valley Hospital
810 Jasmine - Omak, WA. 98841 - 509 826-1760

CHARITY CARE CHECK LIST

PATIENT NAME: __________________________________ ACCOUNT #: ______________

RESPONSIBLE PARTY: _____________________________ BALANCE: $ ______________

Mid−Valley hospital offers a Charity Care Program to medically indigent persons.

To apply for the program, you MUST return the following:

1.__________________ Proof of family income for the last 6−12 months*
*Examples are check stubs or bank statements.
If you didn't have an income, write a statement that explains that.

2.__________________ Copy of last year's income tax return, or a letter attached as to why you didn't file one.

3.__________________ Denial from D.S.H.S., if you applied.

4.__________________ This application must be returned within 30 days. If you are unable to do that, call the business office to let them know when to expect your application.

** Do not send in the application until you have all of the information necessary to process your application **

If you have any questions, please contact Tammy at 509−861−2440

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CHARITY CARE ELIGIBILITY DETERMINATION APPLICATION

Application Date:

Patient Name:

Account Number:

Date of Service:

PERSONS IN FAMILY

Guarantor: ________________________ Spouse: ______________________

Number of Children Living with you: _________

Family income that last 12 months:

Guarantor: $ _______________
Spouse: $ _______________
Other: $ _______________

Do you have an account at Mid−Valley Medical Group? Yes ___ No ___

I understand that the information I submit is subject to verification by Mid−Valley Hospital Staff and possible review form Federal and/or State enforcement agencies as required. I certify that the above information is true and correct. I authorize Employment Security to release all household income for the previous tax year and/or last 12 months to Mid−Valley Hospital, if required.

GUARANTOR _________________________________ DATE _________________________

SPOUSE _____________________________________ DATE _________________________

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Please fill out both pages and sign where needed:

CHARITY CARE APPLICATION

GUARANTOR

EMPLOYER ______________________________ OCCUPATION ____________________

ADDRESS ____

PHONE _____________________________________ YEARS EMPLOYED _______________

SALARY ____________________________________ PER ❑ HOUR ❑ WEEK ❑ MONTH

PAYDAYS ____

SPOUSE

EMPLOYER ______________________________ OCCUPATION ____________________

ADDRESS ____

PHONE _____________________________________ YEARS EMPLOYED _______________

SALARY ____________________________________ PER ❑ HOUR ❑ WEEK ❑ MONTH

PAYDAYS ____

OTHER INCOME

AMOUNT OF INCOME ____________________________ SOURCE ____________________

____

REASON FOR EXTENSION OF PAYMENTS (SPECIAL PROBLEMS−SICKNESS UNUSUAL BILLS)

____

____

____

	MONTHLY PAYMENT	PRESENT BALANCE
RENT/MORTGAGE		
ELECTRIC/GAS		
TELEPHONE		
GROCERIES		
CLOTHING		
AUTO MAINTENANCE		
INSURANCE: AUTO		
OTHER		
OTHER		
PHARMACY		
LOANS: AUTO		
OTHER		
CREDIT CARD		
CREDIT CARD		
MISC		
MISC		
CHILD SUPPORT		
ALIMONY		

TOTAL PAYMENTS $ ______________________

SIGNATURE GUARANTOR

TOTAL INCOME $ ______________________

BALANCE $ ______________________

SIGNATURE SPOUSE