Jamestown HealthCARE

Financial Assistance

JAMESTOWN
FAMILY HEALTH CLINIC

Jamestown HealthCARE is committed to providing community-wide access to anyone in need. Our Financial Assistance module was created to eliminate financial constraints that would otherwise be a barrier to medically necessary care.

Depending on your household income and family size, you may be eligible for fee discounts. We have staff available to assist with completing your application, eligibility, and applying for medical insurance.

Jamestown HealthCARE has expanded our fee schedule to exceed Federal Poverty Guidelines to better serve our patients.

Our Financial Assistance will apply to any medically necessary services provided by a licensed medical professional within Jamestown HealthCARE, depending on your eligibility.

How to apply for Financial Assistance:

- *Complete the attached application.*
- *Obtain proof of income for anyone 18+ years old residing in your household. (Last 3 months)*
- *Current pay stubs (Last 3 months)*

Return the documents noted above in person to Jamestown Family Health Clinic or by fax to 360-582-4800.

Eligibility will be based on review of the application, family size, and income. We will notify you of the final determination within 14 calendar days of receiving a completed application accompanied by the required documentation.

We want to help. Please submit your application promptly!

Jamestown Family Health Clinic
808 N 5th Ave
Sequim, WA 98382
Ph. 360-683-5900
Fx. 360-582-4800

Jamestown HealthCARE

Financial Assistance Application-Confidential

Please fill out all information completely. If it does not apply, please check "No" or write NA.

PATIENT AND GUARANTOR INFORMATION

First name:	Middle name:	Last name:	
Gender: □ Male □ Female □ Other	Date of birth:	Social Security No.	
Mailing address:		Phone number:	
Guarantor financially responsible:	Guarantor date of birth:	Guarantor Social Security No.	Guarantor relationship to patient:

Employment status: □ Employed -hire date:_____ □ Unemployed -as of date:_____ □ Disabled □ Retired □ Other:

SCREENING INFORMATION

Do you need an interpreter?	□ No □ Yes *If yes, list preferred language:*
Does the patient currently have health insurance?	□ No □ Yes
Has the patient applied for WA state Medicaid?	□ No □ Yes *May be required before being considered for financial assistance*
Is the patient eligible for Indian Health Services?	□ No □ Yes *If yes, list tribe:*
Is the patient currently homeless?	□ No □ Yes

FAMILY INFORMATION

List all family members residing in your household. Family includes people related by birth, marriage, and legal adoption.

Family size: _____

Name:	Date of birth:	Relationship:	Employer/Income source (If 18+ yrs old)	Gross monthly income (If 18+ yrs old)

All adult family members income must be disclosed. Sources of income include, for example: Gross Wages (before taxes and deductions) - SSI - Unemployment - Self-employed - Pension - Disability - Workers Compensation - Child/spousal support - Retirement distribution - Other -

INCOME INFORMATION

REMEMBER: YOU MUST INCLUDE PROOF OF INCOME FOR YOURSELF AND ANY FAMILY MEMBER OVER 18YRS OLD

Income verification is required to determine financial assistance.

Examples of proof of income include:

- W-2 withholding statement
- Current pay stubs (3 months)
- Bank statements (3 months)
- Last years income tax return
- Written, signed statement from employer stating your current financial situation if you have no proof of income.
- Forms approving or denying unemployment compensation

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MONTHLY EXPENSE INFORMATION	
We use this information to get a more complete picture of your financial situation.	
Rent/Mortgage	$
Utilities	$
Insurance Premiums	$
Medical Expenses	$
Child Support	$
Loans	$
Other	$

ADDITIONAL INFORMATION

- If you need any assistance completing this application, contact our office at 360-683-5900.
- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may ask for addition information.
- We will notify you of the final determination of eligibility within 14 calendar days of receiving this completed application accompanied by the required documentation.
- You may continue to receive bills until determination has been made.
- Applicants are expected to notify Jamestown Family Health Clinic of any income or household size changes.
- Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as financial hardship, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that Jamestown HealthCARE may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result will be denial of financial assistance.

I am aware that all external services such as but not limited to, lab fees and/or diagnostic imaging, are not included in this financial assistance agreement.

I understand I am responsible for and expected to pay for the services provided.

Signature of person applying: _____ Date: _____

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Do not write below this line - Administrative Use Only