

Cascade Medical Center

Application for the "Community Financial Support Program"

Cascade Medical Center encourages you to apply for our Community Financial Support Program if you are low income and need help paying hospital/clinic charges for inpatient or outpatient care. The Community Financial Support Program is a unique sliding "co-pay" program which is based on your eligibility and income. If you have questions or need help completing this application, please call Dixie Gough - Financial Counselor at 509-548-3436.

Please Print

Personal Information

Patient's Name:

If patient is a minor or a dependent, print name of parent or other responsible party:

Mailing Address: _____

Telephone Number: Home : _____ Cell: _____ Work : _____

Number of people in family (living in household): _____ Their names: _____

Health Insurance information

Medical Insurance? Yes _____ No _____ If "yes," print name of insurance company:

Policy Number: _____

Other Coverage? Yes _____ No _____ Please identify other coverage: _____

Medicare _____ Medicaid _____

Is the medical treatment because of a car accident or other third party injury? Yes _____ No _____

Is the medical treatment because of an on-the-job injury or accident? Yes _____ No _____

Income: Be sure to include with your application documents that give the income amounts you list below. For example:

- ▣ Pay stubs from all household employment (one month's worth) or
- ▣ A "W-2" withholding statement or
- ▣ Last year's income tax return or
- ▣ Letters approving or denying Medicaid, medical assistance, other benefits or
- ▣ Letters approving or denying unemployment compensation or
- ▣ Written statements from employers or welfare agents or
- ▣ Copy of Social Security Income Statement or Bank Deposit Records

Current gross family monthly income (before taxes are taken out): \$ _____

Total family income for the past three months (before taxes are taken out): \$ _____

Has your family had any seasonal or temporary increases or decreases in income? Or, do you expect your income to change in the next three months?

Yes ___ No ___ If yes, please describe: _____

Have you recently suffered severe financial hardship or personal loss (for example, other medical expenses, death of a loved one, loss of job or wages, loss of home, auto, or other property)?

Yes ___ No ___ If yes, please explain: _____

Do the documents that you are including with this application show your current financial situation correctly?

Yes ___ No ___ If no, why not? _____

If you are asking for the Community Financial Support Program for services already provided by Cascade Medical Center, please list dates of services and what services you received:

I understand that the information I am giving will be verified by Cascade Medical Center and reviewed by state and/or federal enforcement agencies and others as required. I certify that the above information is true and accurate to the best of my knowledge.

Applicant's Signature _____ Date _____

Mail this application with all documentation to:

Cascade Medical Center
Attn: Dixie Gough
817 Commercial Ave
Leavenworth, WA 98826

You may also bring this application with all documentation directly to Cascade Medical Center.