Snoqualmie Valley Health

LIVE BOLDLY.
LIVE WELL.

Dear Snoqualmie Valley Health Patient,

We thank you for using Snoqualmie Valley Health for your medical care today. It is our practice to provide our self-pay patients with this Financial Aid Packet to assist in planning to pay for your care.

For uninsured patients that pay their bill within 30 days of receiving their first statement, the Hospital District offers a 30% prompt pay discount. For those who need more time, the Hospital District offers payment plans designed to fit the individual's ability to pay. If a patient is unable to pay for their care, SVH will assist them in how to apply for WA Apple Health and/or Snoqualmie Valley Health Financial Aid. We are available to assist you in person or by phone in completing these forms.

If you have already applied for WA Apple Health and have been denied, please send us your denial letter along with your SVH Financial Aid application and all forms that apply. Eligibility on a completed and approved application is valid for services received within the subsequent 180 days from application approval date. If you need the WA Apple Health application, please call 855-WA FINDER (855-923-4633), or you can apply online at www.wahealthplanfinder.org.

Many Emergency Department patients are eligible for financial aid but do not take advantage of this community service offered by the hospital. In an effort to prevent this from happening to you, we ask that you contact our Financial Aid Coordinator if you have any questions or concerns throughout the process. If you have anything at all that you would care to discuss, please do not hesitate to call.

It is extremely important that we have an accurate mailing address and contact information in order to reach you for assistance in this process. Again, we want to thank you for the opportunity to provide you with excellent customer service, both during your hospital visit and during the financial aid process.

We welcome your questions and comments and are available Monday through Friday from 8 a.m. to 4 p.m. by calling 425-831-2310 to assist you.

Feel free to reach out with any questions or comments. Our team is available to assist you Monday through Friday, from 8 a.m. to 4 p.m. Please call 425-831-2310 for assistance.

Best Regards,
Snoqualmie Valley Health Financial Aid Coordinator
425-831-2310

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Financial Assistance Process

Financial Assistance Applications are available at the Snoqualmie Valley Hospital reception desk as well as on our website.

Complete and send your Financial Assistance Application and all supporting documents to the following address:

Financial Assistance Department
Snoqualmie Valley Hospital
9801 Frontier Ave SE
Snoqualmie, WA 98065
Attn: **Billing Office/Financial Aid**
Phone: (425) 831-2310
Fax: (425) 831-3600

All applications received by our Financial Assistance Department will be processed within 14 days of receipt as follows:

- **Complete Applications** – will be either approved or denied and patient will be notified by mail.
- **Incomplete Applications** – patient will be contacted via phone or letter requesting additional information due in 15 days. If a patient does not respond within this time period, their application will be denied for "lack of information".

Financial Assistance (Charity Care) Application Form Instructions

This is an application for financial assistance (also known as charity care) at Snoqualmie Valley Health.

Washington State requires all hospitals to provide financial assistance to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance.

For emergency and other appropriate services at Snoqualmie Valley Health we provide free care and financial assistance/charity care to eligible patients on a sliding fee scale basis, with discounts raging from 0 to 100% based on federal poverty guidelines, adjusted for family size. Please visit https://aspe.hhs.gov/poverty-guidelines for the current guidelines. You may also visit the Billing and Payment Section of our website, www.snoqualmiehospital.org, to download a copy of our Charity Care policy which includes detailed information on the sliding scale.

What does financial assistance cover? The hospital financial assistance covers appropriate hospital-based services provided by Snoqualmie Valley Health depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

If you have questions or need help completing this application: Snoqualmie Valley Health, 9801 Frontier Ave SE Snoqualmie, WA 98065. PH 425-831-2310. You may obtain help for any reason, including disability and language assistance.

In order for your application to be processed, you must:

- □ **Provide us information about your family**
  Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- □ **Provide us information about your family's gross monthly income (income before taxes and deductions)**
- □ **Provide documentation for family income**
- □ **Attach additional information if needed**
- □ **Sign and date the form**

Note: **You do not have to provide a Social Security number to apply for financial assistance**. If you provide us with your Social Security number it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

Mail or fax completed application with all documentation to: Snoqualmie Valley Health, Attn: Business Office, 9801 Frontier Ave SE, Snoqualmie, WA 98065. FAX 425-831-3600. Be sure to keep a copy for yourself.

To submit your completed application in person: Any Snoqualmie Valley Health Front Desk located at 9801 Frontier Ave SE, Snoqualmie, WA 98065. Business Hours Mon-Fri 8am-4pm.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly!
You may receive bills until we receive your information.

Financial Assistance (Charity Care) Application Form – confidential

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION

Do you need an interpreter? □ **Yes** ☑ **No** *If Yes, list preferred language:*

Has the patient applied for Medicaid? □ **Yes** ☑ **No** *May be required to apply before being considered for financial assistance*

Does the patient receive state public services such as TANF, Basic Food, or WIC? □ **Yes** ☑ **No**

Is the patient currently homeless? □ **Yes** ☑ **No**

Is the patient's medical care need related to a car accident or work injury? □ **Yes** ☑ **No**

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION

Patient first name	Patient middle name		Patient last name
□ Male □ Female □ Other (may specify _____)	Birth Date		Patient Social Security Number (optional*) **optional, but needed for more generous assistance above state law requirements*
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional*) **optional, but needed for more generous assistance above state law requirements*
Mailing Address _____ _____ City State Zip Code			Main contact number(s) ( ) _____ ( ) _____ Email Address: _____

Employment status of person responsible for paying bill

□ **Employed** (date of hire: _____) □ **Unemployed** (how long unemployed:_____)

□ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

FAMILY SIZE _____ *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (*please explain*_____)

Charity Care/Financial Assistance Application Form – confidential

INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application.*

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.

Examples of proof of income include:

- A "W-2" withholding statement; or
- Current pay stubs (*1 months*); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

EXPENSE INFORMATION

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

Rent/mortgage $_____ Medical expenses $_____

Insurance Premiums $_____ Utilities $_____

Other Debt/Expenses $_____ (*child support, loans, medications, other*)

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that Snoqualmie Valley Health may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

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 may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

_____ _____

Signature of Person Applying Date

Dear Snoqualmie Valley Health Patient,

We thank you for choosing Snoqualmie Valley Health for your care. It is our mission to promote the health and well-being of people in our community. This includes assisting our patients in gaining access to healthcare on an on-going basis.

Beginning January 2014, Washington State started offering healthcare coverage to a wider range of residents through a program called Washington Apple Health. You may be required to apply for this program before your Financial Aid application through Snoqualmie Valley Health can be processed, should you meet the qualifications below.

What are the benefits of applying for Washington Apple Health?

- More people than ever before are now eligible for health insurance.
- Coverage is not limited to only one hospital or clinic, as is the case with Financial Aid

Who qualifies for Washington Apple Health?

- The program is available to individuals aged 19-65 years of age.
- Children, pregnant women, and families (parents/caretakers/relatives)

If your family's income is at or less than the figures below, you probably qualify for Medicaid/Apple Health. You may apply at any time.

1 person	2-person family	3-person family	4-person family	5-person family	6-person family	7-person family	8-person family
$20,784	$28,200	$35,640	$43,056	$50,472	$57,912	$65,328	$72,756

Source: 2025 Poverty Guidelines, https://aspe.hhs.gov/poverty-guidelines

**Please note, the above scale is for Medicaid eligibility. It is not the eligibility scale for SVH Financial Aid.*

How do I apply for Washington Apple Health?

- You may apply online at www.wahealthplanfinder.org.
- In-person assistance is available Monday through Friday 9 a.m. to 4 p.m., by appointment only.
    - Appointments are located within Snoqualmie Valley Hospital, located at 9801 Frontier Ave SE, Snoqualmie, WA 98065.
    - For transportation assistance within Snoqualmie Valley call 425-888-7001.

Financial Aid is still available to Snoqualmie Valley Health patients who do not qualify for Medicaid/Apple Health. Please contact us with any questions at 425-831-2310.

Best Regards,
Snoqualmie Valley Health
Patient Account Representative