SKAMANIA COUNTY COMMUNITY HEALTH

Financial Assistance Eligibility Form - CONFIDENTIAL

2024

Individuals who have a Federal Adjusted Gross Income (FAGI) below 220% of the Federal Poverty Level are eligible for payment assistance. Only those amounts deemed taxable will be used to calculate the applicant's adjusted gross income and eligibility for the programs.

SCREENING INFORMATION

Have you applied for Medicaid? (PLEASE CIRLCLE ONE) YES NO

PLEASE NOTE

- **We cannot guarantee that you will qualify for financial assistance even if you apply.**

PATIENT INFORMATION

First Name:	Middle Initial:	Last Name:
Date of Birth:	SSN # (optional):	
Mailing Address:		
City:	State:	Zip:
Phone Number:		

FAMILY INFORMATION

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

FAMILY SIZE_____

Name	Date of Birth	Relationship to Patient

INCOME INFORMATION

All adult family members' income must be disclosed. Sources of income include: (PLEASE MARK ALL THAT APPLY)

___Wages ___Unemployment ___Self-employment ___Worker's compensation ___Disability ___SSI
___Child/spousal support ___Assistance from outside household ___Pension ___Retirement distributions
___Veterans Administration ___Public Assistance ___Other(please explain_____)

REMEMBER: You must include proof of income with application in order to qualify

Gross Amount Received (per paycheck)	**Who Receives it (self/family member)**	**How Often (monthly/weekly)**	**Total Annual Income** (Monthly x 12; Bi-Weekly x 26; Weekly x 52)
$			**$**
$			**$**
$			**$**
$			**$**
$			**$**

You must provide information on your family's income. Income verification is required to determine financial assistance. <u>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:</u>

- A "W-2" withholding statement
- Current pay stubs (2 most recent); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Disability/Benefit Receipt stub(3 months); or
- Bank Statement (clearly states income source)

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

ADDITIONAL INFORMATION

Please provide any additional information about your current financial situation that you would like us to know, such as a financial hardship, seasonal or temporary income, or personal loss. (or) <u>Why have you not applied for or qualify any longer for Medicaid?</u>

PATIENT AGREEMENT

*I certify that the above financial information is accurate, true and complete to the best of my knowledge. I understand that failure to provide accurate information may result in suspension or termination of services. I also understand that Skamania County Community Health staff are permitted to request additional income verification if income reported appears to be inconsistent or incorrect. <u>**Eligibility will be rechecked as often as once every 3 months.**</u>*

_____ _____

Signature of Applicant Date

2024 FEDERAL POVERTY LEVLES

Family Size	100%	130%	150%	200%	220%
1	$15,060	$19,578	$22,590	$30,120	$33,132
2	$20,440	$26,572	$30,660	$40,880	$44,968
3	$25,820	$33,566	$38,730	$51,640	$56,804
4	$31,200	$40,560	$46,800	$62,400	$68,640
5	$36,580	$47,554	$54,870	$73,160	$80,476
6	$41,960	$54,548	$62,940	$83,920	$92,312
7	$47,340	$61,542	$71,010	$94,680	$104,148
8	$52,720	$68,536	$79,080	$105,440	$115,984

***For families/households with more than 8 persons, add $5380 for each additional person.

***(Staff Use Only)* BASED ON INFORMATION PROVIDED BY CLIENT,**	
_____IS ELIGIBLE FOR ASSISSTANCE	_____IS **NOT** ELIGIBLE FOR ASSISSTANCE