Wallowa County Health Care District

We Treat You Like Family

Dear Patient,

Wallowa Memorial Hospital provides financial aid for patients who qualify.

To apply, just follow these three easy steps:

Step 1: Determine if you qualify

If your total household income is at or below the levels highlighted below, you are eligible for financial assistance. Example: If there are 4 people in your household and your total annual income is $50,200 or less, or your total monthly income is $4,183 or less – you qualify for financial assistance. If you qualify, proceed to Step 2. If not, there may be other ways you can qualify, depending on your situation. Please call Patient Accounts at (541) 426-3111 to inquire.

2018 Guidelines - *Annual*	
Household/ Family Size	200%
1	$24,280
2	$32,920
3	$41,560
4	$50,200
5	$58,840
6	$67,480
7	$76,120
8	$84,760
9	$93,400
10	$102,040
11	$110,680
12	$119,320
13	$127,960
14	$136,600

2018 Guidelines - *Monthly*	
Household/ Family Size	200%
1	$2,023
2	$2,743
3	$3,463
4	$4,183
5	$4,903
6	$5,623
7	$6,343
8	$7,063
9	$7,783
10	$8,503
11	$9,223
12	$9,943
13	$10,663
14	$11,383

Step 2: Complete the simple application form, attached.

Step 3: Mail or bring in your completed form:

Patient Accounts, Wallowa Memorial Hospital
601 Medical Parkway
Enterprise, Oregon 97828
For questions, contact Maleah at (541) 426-3111

You will be contacted within 3 weeks and advised whether your application will be fully or partially funded.

Wallowa Memorial Hospital
601 Medical Parkway • Enterprise, OR 97828

Application for Patient Financial Assistance

Date of Application: _____

Patient Name: _____

Mailing Address: _____

City: _____State: _____Zip: _____

Phone: (_____) _____ Date of Birth: _____

Occupation: _____

Employer: _____

Contact Name: _____Phone Number: _____

Patient Family Members Who Live in Your Household	Relation	Date of Birth	Employer	Income per Month
TOTAL FAMILY INCOME				**$**

Do you **or** your family have insurance? ☐ Medicaid ☐ Medicare ☐ Insurance (Include company name and ID number) _____

Are you a co-signer or guarantor on any loan or contract? ☐ Yes ☐ No

If yes, for whom? _____ To whom? _____ Amount: _____

Are there any unsatisfied judgments against you? ☐ Yes ☐ No

If yes, to whom? _____ Amount: _____

Total Gross Family Income per Month	
Employment Income	$
Child Support/Alimony/AFDC	$
Social Security/Disability	$
Unemployment Income	$
Pension/Retirement/Trust Income	$
Other, please explain	
Total Income per Month	**$**

You must provide proof of income. A copy of your most recent tax return is required to process your application.

I will furnish, to the best of my ability, proof of the above income categories. I affirm that this statement of total **annual** family income of $_____ is true and accurate to the best of my knowledge, and that all statements made by me in this application are true. I understand that the information is subject to verification by Wallowa Memorial Hospital and is subject to review by federal and/or state enforcement agencies and others as required.

_____ _____

Signature of Applicant Date

➢ **This section to be completed by a financial services associate of Wallowa Memorial Hospital** ➢

Date Application Received: _____ Received By: _____

The following documents were provided to verify income:_____

_____ Current Tax Return: _____

Discount:_____% Valid Date:_____ Through:_____
