South Peninsula Hospital

Patient Financial Services
4300 Bartlett Street
Homer, AK 99603
907-235-8101 ~ fax 907-235-0251

Application for Financial Assistance

The mission of South Peninsula Hospital is to provide you with quality medical care regardless of your ability to pay. We can appreciate the dramatic impact unexpected medical bills can have when insurance coverage is not available or is insufficient. We are not able to cover elective or cosmetic procedures with this program. Our application process for assistance requires you to provide a variety of supporting documents to be used in our determination process. Individuals qualifying for financial assistance must meet established criteria.

This is the Confidential Financial Statement to help determine eligibility. Please fill out to the best of your ability and return to the financial counselors by: _____.

Please attach the following documents:

- ☐ **Application (on back page)**
- ☐ A brief written explanation of your circumstances
- ☐ Tax Return for prior year, with copies of W2. If self-employed, please provide 2-years of tax returns and current year to date profit and loss statements.
- ☐ Detailed bank statements for the last 3 months for all accounts
- ☐ Most recent pay stub (showing year to date earnings) for all household members
- ☐ If applicable, benefit statement from Public Assistance (SSDI, PA, WIC, Food Stamps, etc)
- ☐ A Medicaid Denial Letter from the Division of Public Assistance (DPA) is initially required for all patients who:
  - Are under the age of 18, or over the age of 65
  - Are , or were, pregnant at the time of service
  - Are part of a family with children living in the household under the age of 18
  - Had services rendered for a catastrophic illness/injury

To get information about applying for Medicaid you can contact DPA at 907-283-2900 or the South Peninsula Hospital Financial Navigators 907-235-0994.

For all other patients, a Denial Letter from DPA will not initially be required, but it may be requested after review of the Finanical Assistance Application. The patient would then be required to privide the denial before the Financial Assistance approval/denial can be determined.

DEFINITIONS:

HOUSEHOLD: A household consists of all persons who occupy a housing unit (house or apartment), whether they are related to each other or not. If a family and an unrelated individual, or two unrelated individuals, are living in the same housing unit, they would constitute two family units, but only one household.

INCOME: Income includes total annual cash receipts before taxes from money wages and salaries before any deductions, net receipts from self-employment, regular payments from social security, railroad retirement, unemployment compensation, strike benefits from union funds, worker's compensation, veteran payments, public assistance (AFDC, TANF, etc), training stipends, alimony, child support, scholarships, grants, fellowships, dividends, interest, rental income, royalties, periodic receipts from estates or trusts, and net gambling or lottery winnings.

ASSETS: Includes homes/buildings, land, vehicles, boats, recreational vehicles, as well as all bank accounts, retirement savings accounts, stocks, bonds, mutual funds, and any other valuable assets.

CONFIDENTIAL FINANCIAL STATEMENT

☐ **Patient is Deceased**

Name of Applicant	Applicant Social Sec #	Name of Adult Co-Applicant	Co-Applicant Social Security #
Address		Co- Applicant Address	
City/State/Zip		City/State/Zip	
Telephone (Home)	Applicant Date of Birth	Telephone (Home)	Co-Applicant Date of Birth
Applicant Employer		Co-Applicant Employer	
Number of dependent Children / Ages		Dependant Name:	
Dependant Name:		Dependant Name:	

ASSETS		LIABILITIES		
Description	**Current market Value**	**Description**	**Current Balance**	**Mo. Payment Amt.**
Home (assessed value)		Home Mortgage	Current Value	
Other Real Estate		Other Real Estate	Current Value	
Vehicle Yr_____ Make _____		Vehicle Payments		
Vehicle Yr_____ Make _____		Personal Loan		
Boat Yr_____ Make _____ Ft_____		Credit Cards:		
Rec. Veh. Type_____ Yr_____ Ft_____		1.		
Checking: Average Balance		2.		
Savings & Certificates		3.		
Stocks, Bonds, Investments, IRA Retirement		4.		
Other Assets (Describe)				

GROSS MONTHLY INCOME		OTHER MONTHLY EXPENSES	
SOURCES	**AMOUNT**	**DESCRIPTION**	**AMOUNT**
Salary (Self)		**Housing - Rent/Mortgage**	
Salary (adult #2		**Phone/Internet/Cable**	
Social Security Income (Self)		**Utilities (heat, electric, fuel, water etc…)**	
Social Security Income (adult #2)		**Transportation (insurance, gas, payment)**	
Pension Income		**Storage unit**	
Other Income (Child support, rental etc)		**Insurance - (Life, medical, home)**	
Other Income (Child support, rental etc)		**Medical Bills Documentation - Non SPH**	
Alaska PFD		**Daycare**	
Other:		**Prescription Costs**	
Other:		**Other:**	
TOTAL		**TOTAL**	

I AGREE THAT ALL INSURANCE PAYMENTS RECEIVED FOR SOUTH PENINSULA HOSPITAL SERVICES WILL BE APPLIED TO MY ACCOUNT AND THAT THE ANSWERS TO THE STATEMENTS ABOVE ARE TRUE AND FACTUAL TO THE BEST OF MY KNOWLEDGE. I FURTHER UNDERSTAND AND AGREE THAT THE INFORMATION HEREIN PROVIDED IS SUBJECT TO VERIFICATION WITH THIRD PARTIES AND OUTSIDE SOURCES.

Applicant Signature _____ Date _____ Co-Applicant Signature _____ Date _____

OFFICE USE ONLY	Date App Rec'd	All Documentation Attached: Yes No	10-day Letter Date:
	Received by:	D Code : Y N	Denial Letter Date:

Updated: 12/29/20 nld