MY HOSPITAL
Hilo Medical Center
MY COMMUNITY

Hilo Medical Center
Financial Assistance Program Application

Patient Account Number(s): _____

Important: YOU MAY BE ABLE TO RECEIVE PARTIAL OR A FULL WRITE-OFF FOR YOUR CARE. Completing this application will help Hilo Medical Center determine if you are eligible to participate in our financial assistance program for your health care services. Please refer to the Financial Assistance Policy summary to understand patient eligibility requirements.

Instructions: Please complete this application in full and sign the authorization to verify information. Forms may be submitted to the hospital in person, faxed or mailed to:

Hilo Medical Center
Attn: Business Office
1190 Waianuenue Avenue, Hilo, HI 96720
Fax: 808-974-6723
Phone: 808-932-4347

While there is no deadline for submitting this application, please be advised that you are responsible for your bill while this application is being reviewed. Due to the volume of applications, please allow one month for processing. Applications will be reviewed in the order they are received.

APPLICANT INFORMATION		
Email Address:		Family Size:
Last Name:	First Name:	M.I.
Date of birth:	SSN: - -	Phone:
Home Address:	Apt. #	
City:	State:	ZIP Code:
Home Phone:	Cell Phone:	
Gross Monthly Income:		

GUARANTOR (PARENT IF MINOR)		
Email Address:		Relationship to Patient:
Last Name:	First Name:	M.I.
Employer:	Employer Address:	
Home Phone:	Cell Phone:	
Gross Monthly Income:		

PRESUMPTIVE ELIGIBILITY

Uninsured patients who demonstrate one of the Presumptive Eligibility Criteria listed below individually or through the benefits provided to their family are automatically eligible to receive ***reduction in care*** and ***no proof of income will be requested***.

Check As Many As Apply:

- ☐ WIC: WOMEN, INFANTS, AND CHILDREN NUTRITION SERVICES
- ☐ SNAP: SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (FOOD STAMPS)
- ☐ LIHEAP: LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
- ☐ COMMUNITY-BASED MEDICAL ASSISTANCE PROGRAM
- ☐ PATIENT IS INCARCERATED FOR A FELONY FOR AN EXTENDED PERIOD OF TIME AND DEBT INCURRED PRIOR TO INCARCERATION
- ☐ TANF OR TAONF: TEMPORARY ASSISTANCE FOR (OTHER) NEEDY FAMILIES
- ☐ HOMELESSNESS OR RESIDES IN A SHELTER
- ☐ IF APPLICANT IS DECEASED WITH NO ESTATE
- ☐ MEDICAID ELIGIBILITY, BUT NOT ON THE DATE OF SERVICE OR FOR NON-COVERED SERVICE
- ☐ HAWAII PERMANENT SUPPORTIVE HOUSING PROGRAM
- ☐ MENTAL INCAPACITATION WITH NO ONE TO ACT ON PATIENT'S BEHALF
- ☐ PERSONAL BANKRUPTCY
- ☐ ELIGIBLE UNDER VIOLENT CRIME VICTIMS COMPENSATION ACT OR SEXUAL ASSAULT VICTIMS COMPENSATION ACT

**** If you demonstrate Presumptive Eligibility, you do NOT need to supply any income information. You DO still need to sign the Applicant Certification at end of this application. ****

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SUPPLEMENTAL DOCUMENTATION

Please attach a copy (do NOT send originals) of the following documents. (If you demonstrate Presumptive Eligibility, skip to Applicant Certification section at end of application):

Required documents:
Income Verification: (Provide one or more for each employed family member)

- a copy of most recent tax return
- a copy of most recent W-2 and 1099 Forms
- a copy of most recent pay stub
- a verifiable wage statement from your employer if paid in cash
- any other verification from a third party about your income\

As applicable, also submit these documents:
Asset Verification: (Provide all that apply for the patient and guarantor)

- Most recent bank statements (checking & savings)

Dependent Household members (List all members for which you provide support)

Name(s):	Age(s):	Relationship

SOURCE OF MONTHLY INCOME

	Responsible Party/Guarantor	Spouse/Other Household Member
Gross Monthly Employment Income:	$	$
Social Security:	$	$
Disability:	$	$
Pension:	$	$
Unemployment Benefits:	$	$
Alimony:	$	$
VA Benefits:	$	$
Other:	$	$

If you cannot provide any documentation relating to your income, fill out the statement below:

I, _____ (name), certify that I have no documents that prove my family's monthly income of $_____.

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ASSETS

Bank Name:	Type of Account:	Latest Ending Statement Balance:
		$
		$
		$
		$

APPLICANT CERTIFICATION: I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal, or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Responsible Party (Guarantor): _____Date: _____
(Signature)

If you have submitted a financial assistance application in the past 60 days and would like to know the status of your application please contact Patient Financial Services directly at (808) 932-3420.

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