WAHIAWA GENERAL HOSPITAL
128 Lehua Street, Wahiawa, HI 96786

FINANCIAL ASSISTANCE *- Help for those in Need*

As part of its contribution of resources, advocacy and community support to promote the health status of the community it serves, Wahiawa General Hospital provides financial assistance to patients with a demonstrated inability to pay for medically necessary services in accordance with the hospital's Financial Assistance Policy. All patients (including those with insurance) may apply for financial assistance by submitting a completed financial assistance application in accordance with the instructions on the application. The patient's situation will be evaluated according to relevant circumstances, such as income, assets or other resources available to the patient or the patient's family and the amount of the outstanding balance. It is ultimately the patient's responsibility to provide the necessary information to qualify for financial assistance. There is no assurance that the patient will qualify for financial assistance.
Examples of Proof of Household income:

- *Most recent pay stubs for all employed household members, if self-employed, a copy of most recent federal income tax filed; proof of worker's compensation, sick leave, disability compensation, welfare, social security income, alimony, child support income; proof of any other income source not listed.*

When all of the information has been received, Wahiawa General Hospital will review the application based on an established eligibility criteria and discount guidelines to determine what amount, if any, of an outstanding patient account balance qualifies for financial assistance.

- Private pay patients whose yearly household income is at or below 200% of the Federal Poverty Guidelines (FPG) will receive a 100% discount.
- Private pay patients whose yearly household income is above 200% but not more than 400% of Federal Poverty Guidelines (FPG) are eligible to receive services at a discounted rate.
- Patients whose outstanding balance, after payment by all insurances and third parties, is at or above 25% of their gross annual household income are eligible to receive services at a discounted rate.

No patient who qualifies for financial assistance will be charged more for emergency or other medically necessary care than amounts generally billed to patients with insurance.

Free copies of the Financial Assistance Policy, and the Financial Assistance Application are available below or at the hospital's admissions area and emergency department registration area. They can also be obtained by calling (877) 418-1082, or requesting by mail at 128 Lehua Street, Wahiawa, HI 96786. Translations will be available upon request.

The hospital's financial counselor is available to answer questions and provide information about the Financial Assistance Policy and to assist with the financial assistance application process. The hospital's financial counselor may be reached between the hours of 8:30 am and 5:00 pm, Monday through Friday by calling (808) 621-4228.

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MEDICAL ASSISTANCE PROGRAM APPLICATION

DATE OF REQUEST_____

PATIENT'S NAME: _____TELEPHONE:_____

ADDRESS :_____(street)

_____(city, state, zip code)

MARTIAL STATUS: _____ SOC SEC #: __ __ __-__ __-__ __ __ __

ACCOUNT #:_____DATE(S) OF SERVICE: _____

DO YOU HAVE OTHER HEALTH INSURANCE? YES_____ NO_____ (If YES, need copy of card)

NAME OF SPOUSE OR GUARNTOR: _____

ALL SOURCE(S) OF INCOME: _____

PATIENT'S EMPLOYER: _____ LAST DAY WORKED: _____

SPOUSE'S EMPLOYER: _____ LAST DAY WORKED: _____

GROSS ANNUAL FAMILY INCOME (include proof of income such as: check stubs, W-2 forms, income tax returns, etc.):

SELF: $_____
SPOUSE: $_____
OTHER: $_____
TOTAL: $_____

NUMBER OF DEPENDENTS ON INCOME (Include Self):_____

PROVIDER OF FINANCIAL INFORMATION (If other than patient or guarantor):

NAME: _____
ADDRESS: _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT IS SUBJECT TO VERIFICATION BY WAHIAWA GENERAL HOSPITAL AND SUBJECT TO REVIEW BY GOVERNMENTAL AGENCIES.

SIGNATURE OF REQUESTOR: _____
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DO NOT COMPLETE (To be completed by Hospital Personnel only.)

This document was received on:_____By:_____
(Name & Title)