Notice of KVH Financial Assistance Program

Kittitas Valley Healthcare is committed to ensuring our patients get the hospital care they need regardless of ability to pay for that care. Providing health care to those who cannot afford to pay is part of our mission and state law requires hospitals to provide free and discounted care to eligible patients. You may qualify for free or discounted care based on family size and income, even if you have health insurance.

If you think you may have trouble paying for your health care, please talk with us. When possible, we encourage you to ask for financial help before receiving medical treatment.

What Is Covered? For emergency and other appropriate hospital-based services at Kittitas Valley Healthcare we provide free care and financial assistance to eligible patients on a sliding fee scale basis, with discounts ranging from 20% to 100%.

How to Apply: Any patient may apply to receive financial assistance by submitting an application and providing supporting documentation. If you have questions, need help, or would like to receive an application form or more information, please contact us:

- When you are checking in or checking out of the hospital;
- By telephone: (**509) 933-7553**
- In person: **603 S Chestnut Street Ellensburg, WA 98926**

If English is Not Your First Language: Translated versions of the application form are available upon request.

Other Assistance:

Coverage Assistance: You may be eligible for other government and community programs. We can help you learn whether these programs (including Medicaid/Apple Health) can help cover your medical bills. We can help you apply for these programs.

Payment plans: Any balance for amounts owed by you can be paid in any of the following ways: credit card, payment plan, cash, or check. If you need a payment plan, please call the number on your billing statement.

Emergency Care: Kittitas Valley Healthcare has a dedicated emergency department and provides care for emergency medical conditions (as defined by the Emergency Medical Treatment and Labor Act) without discrimination consistent with available capabilities, without regard to whether or not a patient has the ability to pay or is eligible for financial assistance.

Thank you for trusting us with your care.

Financial Assistance Application Instructions

This is an application for financial assistance at Kittitas Valley Healthcare.

Washington State requires all hospitals to provide financial assistance to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, *even* if you have health insurance.

What does financial assistance cover? The hospital financial assistance covers appropriate hospital- based services provided by Kittitas Valley Healthcare depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations. Retail pharmacy and custom orthotics are not covered under Financial Assistance.

If you have questions or need help completing this application:

Please call **(509) 933-7553** or come in person to **603 S Chestnut Street Ellensburg, WA 98926.** You may obtain help for any reason, including disability and language assistance.

In order for your application to be processed you must:

- **Provide us information about your family.** Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together).
- **Provide us information about your family's gross monthly** income (income before taxes and deductions).
- **Provide documentation for family income.**
- **Attach additional information if needed.**
- **Sign and date the form.**

Note: You do not have to provide a Social Security number to apply for financial assistance. Social Security numbers are used to *verify* information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

Mail or fax completed application with all documentation to: KVH Hospital Attn: Patient Financial Services 603 S Chestnut St, Ellensburg, WA 98926 or via fax to (509) 933-8815. Be sure to keep a copy for yourself.

To submit your completed application in person: Please drop off at 603 S Chestnut Street (KVH Campus).

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income.
By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly!
You may receive bills until we receive your information.

Kittitas Valley Healthcare
Your Home for Health

KVH Financial Assistance Program
2026 Fee Schedule

Poverty Level*	At or below 200%	201-250%	251-300%	301-400%
Family Size	Discount			
	100%	75%	50%	0%
1	$0 - $31,920.00	$31,921.00 - $39,900.00	$39,901.00 - $47,880.00	$47,881.00 and higher
2	$0 - $43,280.00	$43,281.00 - $54,100.00	$54,101.00 - $64,920.00	$64,921.00 and higher
3	$0 - $54,640.00	$54,641.00 - $68,300.00	$68,301.00 - $81,960.00	$81,961.00 and higher
4	$0 - $66,000.00	$66,001.00 - $82,500.00	$82,501.00 - $99,000.00	$99,001.00 and higher
5	$0 - $77,360.00	$76,361.00 - $96,700.00	$96,700.00 - $116,040.00	$116,041.00 and higher
6	$0 - $88,720.00	$88,721.00 - $110,900.00	$110,901.00 - $133,080.00	$133,081.00 and higher
7	$0 - $100,080.00	$100,081.00 - $125,100.00	$125,101.00 - $150,120.00	$150,121.00 and higher
8	$0 - $111,440.00	$111,441.00 - $139,300.00	$139,301.00 - $167,160.00	$167,161.00 and higher
For Each Additional Person, Add:	$11,360.00	$14,200.00	$17,040.00	$24,840.00

Kittitas Valley Healthcare

Financial Assistance Application Form - confidential

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION

Do you need an interpreter? ☐ **Yes** ☐ **No** *If Yes, list preferred language:*

Has the patient applied for Medicaid? ☐ **Yes** ☐ **No**

Does the patient receive state public services such as TANF, Basic Food, or WIC? ☐ **Yes** ☐ **No**

Is the patient currently homeless? ☐ **Yes** ☐ **No**

Is the patient's medical care need related to a car accident or work injury? ☐ **Yes** ☐ **No**

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION

Patient First Name	Patient Middle Name	Patient Last Name
☐Male ☐Female ☐Other (may specify _____)	Birth Date	Patient Social Security Number (Optional)
Mailing Address _____ _____ City State Zip Code		Main Contact Number(s) ( ) _____ ( ) _____ Email Address: _____

Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (Optional)

Employment status of person responsible for paying bill

☐ **Employed** (date of hire: _____) ☐ **Unemployed** (how long unemployed:_____)

☐ **Self-Employed** ☐ **Student** ☐ **Disabled** ☐ **Retired** ☐ **Other** (_____)

FAMILY INFORMATION

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

FAMILY SIZE _____ *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
		SELF			Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (*please explain*_____)

Kittitas Valley Healthcare

Financial Assistance Application Form - confidential

INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application.*

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

- A "W-2" withholding statement; or
- Current pay stubs (3 *months*); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

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

EXPENSE INFORMATION

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

Rent/mortgage $_____ Medical expenses $_____

Insurance Premiums $_____ Utilities $_____

Other Debt/Expenses $_____ (*Child support, Loans, Medications, other*)

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that Kittitas Valley Healthcare may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

_____ _____

Signature of Person Applying Date