HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI PALI MOMI STRAUB WILCOX

Dear Patient,

Thank you for choosing Hawaiʻi Pacific Health for your health care needs. Our Financial Assistance Program assists patients and their families with the payment of medical bills for services rendered at our facilities or by a Hawaiʻi Pacific Health physician.

Residents of the state of Hawaiʻi receiving medically necessary services or non-residents receiving emergency care may be eligible for financial assistance based on the following criteria:

- Your family income falls at or below 400 percent of current Federal Poverty Guidelines (FPG) for the state of Hawaiʻi.
- If your family income exceeds the 400 percent threshold, you may be considered medically indigent and eligible for financial assistance if your patient balance exceeds 15 percent of your combined family income and liquid assets. You will be required to disclose all forms of income and assets.
- You must have submitted a complete Financial Assistance Application to Hawaiʻi Pacific Health and cooperated with Hawaiʻi Pacific Health to secure third-party funding.

To apply for financial assistance, please complete the enclosed Financial Assistance Application form and submit it with copies of the required supporting documentation outlined on the enclosed checklist.

Send the completed Financial Assistance Application and the required supporting documentation to:

Hawaiʻi Pacific Health
Attn: Financial Assistance Team
888 S. King Street, Tube 31
Honolulu, HI 96813

If you have any questions, please contact our Customer Service office at 522-4013 on Oʻahu, 245-1119 on Kauaʻi, or toll free at 1-866-266-3935.

Sincerely,

Hawaiʻi Pacific Health

Enclosure

HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI PALI MOMI STRAUB WILCOX

Financial Assistance- Documentation Checklist

Your application must include copies of any of the following documents that apply to you. Please attach copies, not originals, as they will not be copied or returned. If any of the documents are missing, it will delay processing of your application.

Please provide information for ALL family members listed on the Financial Assistance Application form. A family member is someone who is related based on birth, marriage, or adoption and residing together.

- ☐ Income verification
  - Wages (Salary)
    - Pay stubs for the last three months
    - Most recent W2's
  - Self-employed
    - GE tax forms
    - Schedule C and/or profit and loss statement
  - Social Security
    - 1099 forms
    - Benefit award letter or bank statement confirming deposit from US Treasury
  - Unemployment
    - "Determination of Insured Status" letter
    - If unable to obtain letter, enclosed is our Income Verification Form (F3) to be completed by BOTH you and the Unemployment office
  - Workers' Compensation
    - Pay stubs for the last three months
    - Benefit award letter
  - Pension/Retirement
    - Pay stubs or statement showing monthly benefit
  - Veteran's benefits
    - Pay stubs or statement showing monthly benefit
  - Rental/Real Estate
    - Schedule E
  - Child Support
    - Benefit award letter or Court document showing amount of income
  - Financial Assistance (Welfare)
    - Benefit award letter or document showing amount of income
- ☐ Complete copy of your most current tax forms filed
  - Must include supporting documents for BOTH earned and unearned income 1099 forms
- ☐ Complete 4506-T form (Request for Transcript of Tax Return) https://www.irs.gov/pub/irs-pdf/f4506t.pdf
- ☐ If receiving support by a family member or friend, the enclosed Statement of Support or Residency Form (F2) will need to be completed by BOTH you and your supporters.
- ☐ Documents showing approval or denial of Medicaid and/or Quest eligibility.
- ☐ If you do not have any of the above mentioned items, please provide a signed statement explaining why you have not submitted those items.
- ☐ Completed and signed Hawaiʻi Pacific Health Financial Assistance Application

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FINANCIAL ASSISTANCE APPLICATION (F1)

SECTION ONE: PATIENT INFORMATION (PLEASE PRINT)			
Name (Last, First, Middle Initial)	Date of Birth	Account Number	Service Date(s)

SECTION TWO: PERSON RESPONSIBLE FOR BILL/ GUARANTOR INFORMATION (PLEASE PRINT)				
Name (Last, First, Middle Initial)			Date of Birth	Social Security Number
Address	City	State	Zip Code	Primary Phone
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Other:_____		Do you file a Federal Tax Return? ☐ Yes ☐ No If no, why? _____		Secondary Phone

SECTION THREE: FAMILY INFORMATION (List all family members who live in your household) Please continue on back of page if more space is needed				
Name of Family Member	**Date of Birth**	**Social Security Number**	**Relationship to Patient**	**Is this person listed on your Federal Tax Return?**
1.				☐ Yes ☐ No
2.				☐ Yes ☐ No
3.				☐ Yes ☐ No
4.				☐ Yes ☐ No
5.				☐ Yes ☐ No
6.				☐ Yes ☐ No

SECTION FOUR: EXPENSES (List monthly expenses for all family members)		
Rent: $	Mortgage: $	Other Total Expenses: $

SECTION FIVE: MONTHLY GROSS INCOME (List income for all family members before taxes)			
Wages (Salary)	Workers' Compensation	Rental/Real Estate	Other Income
Social Security	Pension/Retirement	Child Support	Source:
Unemployment	Veterans' Benefits	Financial Assistance (Welfare)	Amount:

I understand Hawaii Pacific Health may verify the financial information contained in this Financial Assistance Application in connection with Hawai'i Pacific Health's evaluation of this application, and by my signature hereby authorize my employer or any individual listed on this application to certify or provide additional details with respect to the information provided in this application. I certify that the statements made in this application are true and correct, to the best of my knowledge and belief, and are made in good faith. I am aware that falsification or misrepresentation of information on this application may result in denial of financial assistance.

I further understand that some physicians and providers may not be employees of Hawai'i Pacific Health. I understand that I may receive separate bills from those providers and this financial assistance application will not apply to those balances due.

_____ _____

Signature of Patient/Guarantor **Date**

_____ _____

Print Name **Relationship to Patient**

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Statement of Support and/or Residency Form (F2) for Patient's Applying for Financial Assistance

If you are receiving any type of support, we will need both you and your supporter(s) to complete this form. If you are receiving support from multiple persons, each supporter will need to complete a "Part B" of this form.

Part A: To be completed by the patient/guarantor:

I,_____, state that I am currently residing at
(Patient/Guarantor Name)

_____
(Address)

I have been supported by _____ _____
(Name of Supporter) (Relation)

Supporter(s) has/have been Providing the following: (Please check all that apply) [

] Housing [ ] Food [ ] Monetary [ ] Other day-to-day expense

_____ _____
Patient/Guarantor Signature Date

Part B I: To be completed by supporter:

I,_____, state that I am currently providing
(Supporter's Name)

_____, with the following:
(Patient/Guarantor Name)

(Please check all that apply)

[ ] Housing [ ] Food [ ] Monetary [ ] Other day-to-day expense

If monetary, total monies provided:

_____ _____
(This month) (Amount)

_____ _____
(Last month) (Amount)

_____ _____
(Two months ago) (Amount)

_____ _____
Supporter Signature Date

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Part B II: To be completed by supporter:

I,_____, state that I am currently providing
(Supporter's Name)

_____, with the following:
(Patient/Guarantor Name)

(Please check all that apply)

[ ] Housing [ ] Food [ ] Monetary [ ] Other day-to-day expense

If monetary, total monies provided:

_____ _____
(This month) (Amount)

_____ _____
(Last month) (Amount)

_____ _____
(Two months ago) (Amount)

_____ _____
Supporter Signature Date

Part B III: To be completed by supporter:

I,_____, state that I am currently providing
(Supporter's Name)

_____, with the following:
(Patient/Guarantor Name)

(Please check all that apply)

[ ] Housing [ ] Food [ ] Monetary [ ] Other day-to-day expense

If monetary, total monies provided:

_____ _____
(This month) (Amount)

_____ _____
(Last month) (Amount)

_____ _____
(Two months ago) (Amount)

_____ _____
Supporter Signature Date

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Unemployment Income Verification Form (F3) for Patient's Applying for Financial Assistance

If you are receiving unemployment benefits, this form will need to be completed to determine eligibility for our Financial Assistance Program. Please complete Part A of this form and have an authorized representative at the Unemployment Office complete Part B.

Part A: To be completed by the person receiving unemployment benefits

Name: _____ Social Security#: _____

Address: _____ Telephone#: _____

_____

_____

I hereby authorize the Department of Labor & Industrial Relations, Unemployment Insurance Division to release information regarding my unemployment benefits. This information will be used for the sole purpose of determining eligibility for Hawaii Pacific Health's Financial Assistance Program.

Signature of person receiving unemployment benefits Date

Part B: To be completed by a representative for the State of _____

Department of Labor & Industrial Relations, Unemployment Insurance Division.

Unemployment Benefit Information

Weekly Benefit amount: _____

Maximum benefit entitlement: _____

Benefit year begin: _____ Benefit year end: _____

Print Name: _____ Title: _____

_____ _____

Contact Number: _____

Signature of representative Date