



301 Cedar  
Orofino, ID 83544  
208.476.4555 tel  
smh-cvhc.org



701 Lewiston Street  
Cottonwood, ID 83522  
208.962.3251 tel  
smh-cvhc.org

**Addendum A**

Date Financial Counselor Received

**Financial Assistance Application**

St. Mary's and Clearwater Valley Hospital and Clinics

We understand that unexpected medical debt can be a financial hardship and we are committed to assist you with your financial obligation. **This application needs to be completed within 21 days and returned to one of the following locations:**

**Mailed to:**

Clearwater Valley Hospital/Clinics  
301 Cedar  
Orofino, ID 83544

**OR**

**Mailed to:**

St. Mary's Hospital/Clinics  
PO Box 137  
701 Lewiston St.  
Cottonwood, ID 83522

**OR** you can drop it off at either hospital or clinics.

In order to process your application, the following information (if applicable) is required:

**Do not send originals and please no staples**

- Current, valid Picture I.D.
- The patient's most recent filed Federal Tax Return (if tax return covers a prior calendar year, then a current W-2 form for all household/family members will also be required).
- Current three months of employer pay stubs
- Copies of all checking, savings and other bank statements for last three months
- Social security benefits
- Disability and/or Unemployment benefits received
- Current food stamps award letter from patient's state of residence
- Written documentation from other income sources.
- A copy of a most recent application denial from County program or Medicaid
- Proof of Assets, to include supporting documentation of:
  - ✓ Value of home (if owned)
  - ✓ Vehicles
  - ✓ Land
  - ✓ Stocks and bonds
  - ✓ Life insurance with cash value
  - ✓ Assets available through a family or other Trust

Please contact Financial Services Counseling at 208-476-4555 or 208-962-3251 if you have any questions. CVH Fax 208-476-5385, SMH Fax 208-962-2478.

*\*We use the Federal Poverty Guidelines when determining eligibility*





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**Patient/Applicant**

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse/Significant Other \_\_\_\_\_ # of Dependents in Home \_\_\_\_\_ Age of Dependents \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Message Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Is Patient a minor? Yes \_\_\_\_\_ No \_\_\_\_\_ Parent/Guarantor \_\_\_\_\_

**LIVING ARRANGEMENT:** Rent \_\_\_\_\_ Own \_\_\_\_\_ Other (explain) \_\_\_\_\_

**Gross Monthly Income**

Self \_\_\_\_\_ Spouse/Significant Other \_\_\_\_\_ Unemployment \_\_\_\_\_ Food Stamps \_\_\_\_\_

Social Security / SSI/ SSD \_\_\_\_\_ Loans / Gifts \_\_\_\_\_ Worker's Comp \_\_\_\_\_ Inheritance / Trust \_\_\_\_\_

Veteran's Benefits \_\_\_\_\_ Child Support \_\_\_\_\_ Pension / Retirement \_\_\_\_\_ Other \_\_\_\_\_

**TOTAL Gross Income \$** \_\_\_\_\_

**Monthly Expenses**

Rent/Mortgage \_\_\_\_\_ Gasoline / Fuel \_\_\_\_\_ Auto Insurance \_\_\_\_\_

2<sup>nd</sup> Mortgage \_\_\_\_\_ Prescriptions \_\_\_\_\_ Car Payment \_\_\_\_\_

Space Rent \_\_\_\_\_ Life Insurance \_\_\_\_\_ Home / Rent Ins. \_\_\_\_\_

Food \_\_\_\_\_ Child Care \_\_\_\_\_ Garnishments \_\_\_\_\_

Electricity/Heat \_\_\_\_\_ Doctor / Hospital \_\_\_\_\_ Fines \_\_\_\_\_



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Water/Sewer/Trash \_\_\_\_\_ Child Support \_\_\_\_\_ Other Expenses \_\_\_\_\_

Telephone \_\_\_\_\_ Health / Accident Ins. \_\_\_\_\_

**TOTAL Monthly Expenses \$** \_\_\_\_\_

**ASSETS**

*All Business & Personal Bank Accounts:*

Checking Account - Bank Name \_\_\_\_\_ Current Balance \_\_\_\_\_

Checking Account - Bank Name \_\_\_\_\_ Current Balance \_\_\_\_\_

Savings Account – Bank Name \_\_\_\_\_ Current Balance \_\_\_\_\_

Savings Account – Bank Name \_\_\_\_\_ Current Balance \_\_\_\_\_

Stocks, CD's, Trusts \_\_\_\_\_ Current Balance \_\_\_\_\_

401K, Retirement, IRAs \_\_\_\_\_ Current Balance \_\_\_\_\_

Life Insurance Cash Value \_\_\_\_\_ Other Assets \_\_\_\_\_ Value \_\_\_\_\_

Home/ Properties \_\_\_\_\_

Value Purchase Date Amount Owed

Land / Rental Properties \_\_\_\_\_

Value Purchase Date Amount Owed

Vehicle \_\_\_\_\_

Year Make Current Value Amount Owed Monthly Payment

Vehicle \_\_\_\_\_

Year Make Current Value Amount Owed Monthly Payment

Vehicle \_\_\_\_\_

Year Make Current Value Amount Owed Monthly Payment



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Recreational (Boat, RV, ATV, MC) \_\_\_\_\_  
Year    Type    Current Value    Amount Owed    Payment

Recreational (Boat, RV, ATV, MC) \_\_\_\_\_  
Year    Type    Current Value    Amount Owed    Payment

I authorize St. Mary's Clearwater Valley Hospital and Clinics to verify the information that I have supplied on this statement to be true and to access credit information if needed.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_