Kahuku Medical Center
Friends and Family Taking Care of Friends and Family

Aloha,

Thank you for choosing Kahuku Medical Center to meet the healthcare needs of you and your ohana. Our Community Care Program provides financial assistance to patients and their families for eligible services rendered at our facility. Eligible services include Hospital, Outpatient Clinic, and Emergency Room services. Non-eligible services include Laboratory, EKG, EEG, Cardiopulmonary, Radiology, and Professional Fees. Residents receiving medically necessary care or non-residents receiving emergency services who wish to apply must complete the following:

- Complete the enclosed application form (F1).
- Apply for Medicaid (DHS) assistance. If denied, attach a copy of your *Medicaid Denial Notice* to your application.
    - Failure to maintain scheduled appointment with "Worker" does not constitute as a bona fide DHS denial.
- Attach a copy of income verification for the past twelve (12) months.
    - See Document Checklist on page 2 for income verification requirements.

Return your completed application along with **copies** of the required supporting documents to:

Kahuku Medical Center
Attn: Patient Account Representative
56-117 Pualalea St.
Kahuku, HI 96731

If you have any questions, please contact Customer Service during normal business hours at (808) 293-9221 and request to speak with a Patient Account Representative.

Sincerely,

Kahuku Medical Center

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Community Care Program (CCP)
Financial Assistance Documentation Checklist

Your Community Care Program application must include copies of the following documents that apply to you. Please include copies and not originals, as these items will not be returned. If any of the necessary documents are missing, it will delay the processing of your Community Care Program application.

Please provide information for ALL family members listed on the Community Care Program Financial Assistance Application form (F1).

☐ Income verification
- Wages
  - Pay stubs for the last three months
  - Most recent W2 or 1099
- 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 (F2) 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
- Complete 4506-T form (Request for Transcript of Tax Return) https://www.irs.gov/pub/irs- pdf/f4506t.pdf

☐ Documents showing approval or denial of Medicaid and/or Quest eligibility
☐ Completed and signed Kahuku Medical Center Community Care Program Financial Assistance Application (F1)

FINANCIAL ASSISTANCE APPLICATION (F1)

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

SECTION TWO: PERSON RESPONSIBLE FOR BILL/ GUARANTOR INFORMATION (PLEASE PRINT)				
Name (Last, First, Middle Initial):			Date of Birth:	Social Security Number:
Street Address:	City:	State:	Zip Code:	Primary Phone:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Do you file a Federal Tax Return? ☐ Yes ☐ No If no, please explain 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:	Workers' Compensation:	Rental/Real Estate:	Other Income: Source: Amount:
Social Security:	Alimony:	Pension/Retirement:	
Unemployment Benefits:	Child Support:	Financial Assistance (Welfare):	

I hereby request that Kahuku Medical Center (KMC) make a written determination of my eligibility for free or reduced medical care. I understand that the information which I provide concerning my annual income, assets, and family size will be subject to verification by KMC. I also understand that if the information provided is determined to be false, such a determination will result in the denial of any approved free medical care, and that I will become financially liable for the services provided.

Name of Patient or Guarantor _____ **Relationship to Patient** _____

Signature of Patient or Guarantor _____ **Date** _____

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Unemployment Income Verification Form (F2) for Patient's Applying for Financial Assistance

Please complete this form (F2) if you are receiving unemployment benefits. Part A of this form is to be completed by the person receiving benefits, and Part B is to be completed by an authorized representative from the Unemployment Office.

Part A: To be completed by the person receiving unemployment benefits (Recipient).

Name: _____ Social Security #: _____

Address: _____

_____

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 financial assistance through Kahuku Medical Center's Community Care Program.

Name of Recipient: _____

Signature of Recipient: _____ Date: _____

Part B: To be completed by a representative for the State of Hawaii Department of Labor & Industrial Relations, Unemployment Insurance Division (Representative).

Unemployment Benefit Information

Weekly Benefit Amount: _____ Maximum Benefit Entitlement: _____

Benefit Period Start: _____ Benefit Period End: _____

Name of Representative: _____

Signature of Representative: _____ Date: _____