The Queen's Health Systems - Hawaii

ACCT. OR MRN ______________

Financial Assistance Application

PATIENT INFORMATION

PATIENT NAME	SSN and/or DATE OF BIRTH	CONTACT PHONE NO.
PATIENT SPOUSE	SSN and/or DATE OF BIRTH	OTHER RESPONSIBLE PARTY and SOCIAL SECURITY NO.

HOME ADDRESS ___ OWN ___ RENT	STREET	CITY	STATE	ZIP

LIST ALL DEPENDENTS

NAME AGE RELATIONSHIP	NAME AGE RELATIONSHIP
1.	3.
2.	4.

FINANCIAL and EMPLOYMENT INFORMATION

List all sources of household income (Employment, Disability, Social Security, Unemployment, etc.)

Name of person receiving income	Income source (employer/position)	Annual amount of income
	Total annual household income	$

Assets greater than $3,000 ☐ **No** ☐ **Yes** (list below)	**Amount**
Total assets	$

	DEBTOR	AMOUNT OWED	MONTHLY PAYMENT
FOOD $	1.	$	$
UTILITIES $	2.	$	$
RENT/MORTGAGE $	3.	$	$
CAR PAYMENT $	4.	$	$

LOCAL, STATE, FEDERAL HEALTH CARE AND OTHER FINANCIAL AID PROGRAM INFORMATION

Have you applied for QUEST or Medicaid? No ____________ Yes _____________ Date Applied ______________________________

Result of application and reason for denial, if applicable: ______________________________

Documents Needed To Process Your Application

Attach documentation (if not previously submitted) on your identity, income and assets:

1. ___ Your driver's license, birth certificate and/or other picture ID or alien card
2. ___ Two most current pay stubs
3. ___ Bank/Credit Union statements for current month
4. ___ Bank/Credit Union statements for two previous months
5. ___ Appraisals or ownership documents for property, motor vehicles, stocks and bonds, jewelry, life insurance and items of value; and provide verifications of any balance due
6. ___ Receipts for rent and any expenses

NOTE:

- ***If married, patient and spouse are required to sign the Discounted Care Policy Application and verifications are required for both.***
- ***Applications are accepted at each hospital location.***
- ***Mail completed application and verifications to:***

The Queen's Medical Center, Attention Business Services
P.O. Box 861, Honolulu   HI 96808-0861

The Queen's Medical Center West Oahu
91-2141 Fort Weaver Road, Ewa Beach, HI 96706

Molokai General Hospital
280 Home Olu Place, Kaunakakai, HI 96748

North Hawaii Community Hospital
67-1125 Mamalahoa Highway, Waimea, HI   96743

I certify that the above is true and correct and is a complete list of all income/assets and expenses/liabilities. You are authorized to obtain such information as you may require to verify the accuracy of the above statements and representations. I understand that any intentional omissions of information will disqualify me from any Discounted Care Program offered by the Queen's Medical Center or subject me to legal action to recover discounted care already approved.

______________________________ ______________
PATIENT SIGNATURE DATE

______________________________ ______________
PATIENT SPOUSE/OTHER RESPONSIBLE PARTY SIGNATURE DATE