MY HOSPITAL
Hilo Medical Center
MY COMMUNITY

Hilo Medical Center
Financial Assistance Program Application

Patient Account Numbers: ______________________________

Important: YOU MAY BE ABLE TO RECEIVE PARTIAL OR A FULL WRITE-OFF FOR YOUR CARE. Completing this application will help Hilo Medical Center determine if you are eligible to participate in our financial assistance program for your health care services. Please refer to the Financial Assistance Policy summary to understand patient eligibility requirements

Instructions: Please complete this application in full and sign the authorization to verify information. Forms may be submitted to the hospital in person, faxed or emailed to

Hilo Medical Center
Attn: Patient Financial Counselor
1190 Waianuenue Avenue
Hilo, Hawaii 96720
Fax: 808-974-6723
Phone: 808-932-4347

While there is no deadline for submitting this application, please be advised that you are responsible for your bill while this application is being reviewed. Due to the volume of applications, please allow one (1) month for processing. Applications will be reviewed in the order they are received.

APPLICANT INFORMATION					
Email address:					
Last name:		First Name:		M.I.	
Date of Birth:		SSN:		Phone:	
Home Address:				Apt #	
City:		State:		Zip Code:	
Home Phone:		Cell Phone:			
Gross Monthly Income:					
GUARANTOR (PARENT IF MINOR) INFORMATION					
Email address:		Relationship to Patient			
Last Name:		First Name:		M.I.	
Employer:		Employer Address:			
Home Phone:		Cell Phone:			
Gross Monthly Income:					

SUPPLEMENTAL DOCUMENTATION

Please attach a copy (do NOT send originals) of the following documents:
Required documents:
Income Verification: (Provide one or more for each employed family member)

- ☐ a copy of most recent tax returns
- ☐ a copy of most recent W-2 and 1099 Forms
- ☐ a copy of most recent pay stub
- ☐ a verifiable wage statement from your employer if paid in cash
- ☐ any other verification from a third party about your income.

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As applicable, also submit these documents:
Asset Verification: (Please provide all that apply for the patient and guarantor)

☐ Most recent bank statements (checking & savings)

Household members: (List all members for which you provide support)

Name(s):	Age(s):	Relationship:

SOURCE OF MONTHLY INCOME		
	Responsible Party/Guarantor	**Spouse/Other Household Member**
Gross Monthly Employment Income	$	$
Social Security	$	$
Disability	$	$
Pension	$	$
Unemployment Benefits	$	$
Alimony	$	$
VA Benefits	$	$
Other	$	$

ASSETS		
Bank Name:	Type of Account:	Latest Ending Statement Balance:
		$
		$
		$
		$

APPLICANT CERTIFICATION: I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal, or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Responsible Party (Guarantor): ______________________________ Date: ________________
(Signature)

If you have submitted a financial application in the past 60 days and would like to know the status of your application please contact our Patient Financial Services directly at (808) 932-4347.