KONA
COMMUNITY HOSPITAL

Aloha Charity Care Applicant:

Please fill out the attached paperwork (2-page application) as best as you can to provide as much information on your financial situation as we can to determine whether you can qualify for free medical care (Charity Care) on a total or reduced basis. We have list what information is needed for us to process your application.

- Most recent year's W2 or most recent Federal tax return form, including all schedules
- Last 3 months' bank statements
- Last 2 take-home pay stubs
- No income: Provide a signed letter explaining daily living support

FAILURE TO COMPLY AND REMIT THE REQUIRED DOCUMENTS WILL RESULT IN YOUR APPLICATION'S REJECTION.

The application process is as follows: Once we receive the completed application and required documentation, we will review it and make a determination. After the review, we will notify you in writing if you are approved or denied for full or partial charity assistance or if reduced payment arrangements are agreed upon. The letter will include the dollar amount you would still be responsible for paying for the reduced or partial assistance.

We appreciate a prompt response. Please submit your information in person at the Kona Community Hospital business office or by mail at the address below.
You can also fax it to (808) 322-0118 or email: kchbilling@hhsc.org

Mailing address:
Kona Community Hospital
Attn: Patient Financial Counselor
79-1019 Haukapila Street
Kealakekua, HI 96750

Please do not hesitate to call us at 808-322-5813 if you have any questions or concerns. Thank you for choosing Kona Community Hospital as your healthcare provider, and look forward to serving you in the future.

Sincerely,

Kona Community Hospital
Patient Financial Services

HAWAII HEALTH SYSTEMS
C O R P O R A T I O N
Quality Healthcare For All

HAWAII HEALTH SYSTEMS CORPORATION
CHARITY PROGRAM APPLICATION

I hereby request that HHSC make a written determination of my eligibility for free medical care. I understand that the information which I provide concerning my annual income, assets, and family size will be subject to verification by HHSC. 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 liable for the charges for the services provided.

ACCOUNT #(S): _____

DATE(S) OF SERVICE: _____

PATIENT (First/M.I./Last): _____

ADDRESS: _____
(Number/Street/Apt.#/City/State/Zip)

FAMILY SIZE: _____ TELEPHONE NO: _____

INCOME (include all income before deductions from sources below for persons listed in family size):

	LAST 3 MONTHS	LAST 12 MONTHS
WAGES	$_____	$_____
SOCIAL SECURITY	$_____	$_____
UNEMPLOY. COMP	$_____	$_____
WORK COMP	$_____	$_____
ALIMONY	$_____	$_____
CHILD SUPPORT	$_____	$_____
PENSIONS	$_____	$_____
INCOME FROM RENT, DIVIDENDS, INTEREST	$_____	$_____
TOTAL INCOME	$_____	$_____

A. Total income for last 3 months $_____ X 4 = $ _____

B. Total income for last 12 months $_____

3675 KILAUEA AVENUE • HONOLULU, HAWAII 96816 • PHONE: (808) 733-4020 • FAX: (808) 733-4460

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www.hhsc.org <http://www.hhsc.org>

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CHARITY PROGRAM APPLICATION

ASSETS (include all assets owned by all persons listed in family size):

REAL PROPERTY (House, Condominium, etc.) $_____

(Excludes the value of the patient's principal place of residence. The value of any real property owned for the purpose of investments shall be included in the computation of income and assets)

BANK ACCOUNTS (Savings, Checking, etc.) $_____

STOCKS, BONDS, ETC. $_____

TOTAL ASSETS $_____

TOTAL INCOME & ASSETS ..... $_____

_____

Patient's/Requestor's Signature Date

Return completed application and required documentation to:

Kona Community Hospital
Email: kchbilling@hhsc.org
Fax: (808) 322-00118
Mail: Kona Community Hospital
Attn: Patient Financial Counselor
79-1019 Haukapila Street
Kealakekua, HI 96750

Kohala Hospital
Email: kohbusinessoffice@hhsc.org
Fax: (808) 731-4688
Mail: Kohala Hospital
Attn: Billing Department
P.O. Box 10
Kapaau, HI 96755