

ELECTRA HOSPITAL DISTRICT
2022 FINANCIAL ASSISTANCE WORKSHEET

Date: _____

Applicant _____

Other household members covered by this application _____

Total Income - _____

of Dependents - _____

INCOME LESS THAN OR EQUAL TO:				
Family Size	Percentage of Federal Poverty Income Guidelines (2020)			
	100%	150%	200%	300%
1	\$13,590	\$20,385	\$27,180	\$40,770
2	\$18,310	\$27,465	\$36,620	\$54,930
3	\$23,030	\$34,545	\$46,060	\$69,090
4	\$27,750	\$41,625	\$55,500	\$83,250
5	\$32,470	\$48,705	\$64,940	\$97,410
6	\$37,190	\$55,785	\$74,380	\$111,570
7	\$41,910	\$62,865	\$83,820	\$125,730
8	\$46,630	\$69,945	\$93,260	\$139,890
For each additional household member add:	\$4,720	\$7,080	\$9,440	\$14,160
PATIENT RESPONSIBILITY				
PROVIDER CLINIC VISIT	\$5	25%	50%	50%
OUTPATIENT	\$20/DAY	25%	50%	50%
EMERGENCY ROOM	\$50	25%	50%	50%
HOSPITAL INPATIENT	\$75/DAY	25%	50%	50%
HOME HEALTH	\$75/CERT PERIOD	25%	50%	50%
GDS/IPP MAX CHARGE	\$20	\$35	\$45	\$45

Applicant(s) qualify for the following:

	Copayment	Percentage
Provider Clinic Visit		
Outpatient		
Emergency Room		
Hospital Inpatient		
Home Health		
GDS/IPP Max Charge		

Applicant is ineligible and denied because: _____

This determination is valid: _____ through _____.

Signature _____

Approved: _____