**The Thurston County Council on Aging**

 **PO Box 7624, Olympia, WA 98506**

**CONFIDENTIAL APPLICATION FORM**

The Thurston County Council on Aging application assistance can only help you with specific medical equipment and supplies. The Items at the Medical Equipment Bank are for home use only, not for business or not to be sold, and shall be returned,

to the Medical Equipment Bank.

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Thurston County Council on Aging Board cannot guarantee we can help you with the medical equipment or supplies or if you will qualify for aid assistance for certain medical supplies or equipment even if you apply.

Please complete the Thurston County Council on Aging application form to determine if you qualify for specific medical equipment or supplies assistance.

The application for help with medical equipment or supplies shall be filled out.

Once you send in your application, we may check all the information and ask for additional information or proof of income.

**For your application to be processed, you must provide us with the information below:**

**APPLICANT INFORMATION, (PATIENT)**

Please Print Clearly: Patient First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Middle Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Birthdate day\_\_\_\_\_, Month, \_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_

Street Address (No PO BOX) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_St. \_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No. \_\_\_\_\_\_\_\_\_\_

Please circle the county you live in Thurston, Mason, Lewis, Other County\_\_\_\_\_\_\_\_\_\_

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**INFORMATION ON THE PERSON FILLING OUT THE APPLICANTION**

Are you the Patient? YES \_\_\_ NO \_\_\_If No, please fill out the information below?

Please Print Clearly: Your Name First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Middle Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address (No PO BOX) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_ Phone No.\_\_\_\_\_\_\_\_\_\_\_

**PATIENT INFORMATION**

Patient, do you have healthcare insurance? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

What is the name of the patient healthcare Insurance Company? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance Policy Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient, did you apply for Medicare? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

Patient, did you apply for Medicaid? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

Medicaid is a government health insurance program available to people with limited Income. To apply for Medicaid, Phone: 360-586-6181, Ext. 134

Do you have a Dr. Prescription for the medical equipment or incontinence

supplies & products for the items you need if Yes \_\_\_\_ or No \_\_\_\_\_

Please attach a copy of the Dr. Prescription form.

Did your insurance company deny your claim for the medical equipment or adult incontinence supplies & products? Yes \_\_\_\_ or No \_\_\_\_

If yes, please attach copy of the denial.

Has the patient received state public services such as

TANF, Basic Food, or WIC? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

Is the Patient currently homeless? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

Are you low-income? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

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**All family members 18 years old or older must disclose their income. You may submit a written signed statement describing your income if you cannot provide documentation. Please provide proof for every identified source of income.**

**Examples of proof of income include:**

**• A "W-2" withholding statement; or**

**• Current pay stubs (3 months); or**

**• Last year’s income tax return, including schedules if applicable; or**

**• Written, signed statements from employers or others; or Approval/denial of eligibility for Medicaid and state-funded medical assistance; or**

If you have no proof of income or no income, please attach an additional page with an explanation.

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| **EXPENSE INFORMATION** |
| *We use this information to get a more complete picture of your financial situation.* |
| Monthly Household Expenses: Rent/mortgage $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical expenses $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance Premiums $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Utilities $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other Debt/Expenses $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*child support, loans, medications, other*)  |

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| --- |
| **ASSET INFORMATION**  |
| *This information may be used if your income is above 300% of the Federal Poverty Guidelines.*  |
| $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Total** Household Income$ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Checking account balance$ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current savings account balance | Do you have these assets? **Please check all that apply.**\_\_\_ Stocks \_\_\_ Bonds \_\_\_ 401K \_\_\_ Trust(s) \_\_\_ Retirement \_\_\_ Rental Property \_\_\_ Health Savings Account\_\_\_ Primary residence \_\_\_ Other Property\_\_\_ Own a business  |

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Once you send in your application, we may check all the information and may ask for additional information or proof of income. •

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

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I understand the Thurston County Council on Aging Board members may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denied of aid assistance for medical supplies, and medical equipment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Print Signature of Patient Applying Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Signature of Patient Applying Date

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