SUMMIT PACIFIC
• MEDICAL CENTER •

Determination of Eligibility for Community Care

Please mail to:
The CBO Solutions
c/o Summit Pacific Medical Center
P.O. Box 2726
Spokane, WA 99220
1-888-292-8810

Date of Request:_____

Patient Name:_____ Patient Account #:_____

Address: _____ Telephone #:_____

☐ ***I have attached to this application a copy of my family's proof of income, as 12 months of income verification is <u>required</u> for determination of community care eligibility. Income verification examples can be paystubs, tax returns, bank statements, etc. If proof of income is not available, or if there is no income to verify, please explain on the back of this application your financial situation.***

Family Size:_____ (Please list family member names and relationship to responsible person)

Family member names:	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Total household income from all sources for the last 12 months: $_____

I affirm that the above information is true and correct to the best of my knowledge. I also understand that if the information that I have submitted is determined to be false, such determination will result in a denial of this application and that I will be liable and be expected to pay for the services provided.

Applicants Signature_____ Date_____