Revised 03/20/2024

MT GRANT GENERAL HOSPITAL

APPLICATION for FINANCIAL ASSISTANCE
APPLICATION/UPDATE/CHANGE FORM

Mailing Address
PO Box 1510
Hawthorne, NV 89415

775-945-2461

Street Address
200 South A Street
Hawthorne, NV 89415

Sliding Fee Discount Information

It is the policy of Mt. Grant General Hospital to provide essential services regardless of the patient's ability to pay. Mt. Grant offers discounts based on family size and annual income. Please complete the following information and submit the most recent bank statement and return it to the front desk to determine if you and/or members of your family are eligible for a discount.

The discount will apply to all services received at the Hospital and Clinic, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. The discount will not apply to the Lefa Seran Nursing Facility. You must complete this form every 12 months or if your financial situation changes.

Legal Name of Applicant: _____ **Phone:** _____

Please list any aliases/previous names: _____ Cell : _____

Current Address: (street) _____ **PO Box**: _____

(city) _____ (state) _____ (zip code) _____

	Name	Date of Birth
SELF		
OTHER		
OTHER		
OTHER		

(Please attach paper with additional household members if needed)

Source	Self	Other	Total
Gross wages, salaries, tips, etc.			
Income from business and self-employment			
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension or retirement income			
Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources			
Total Income			

I certify that the family size and income information shown above is correct.

Name (Print) _____

Signature _____ **Date** _____

Office Use Only

Patient Name: _____ **Approved Discount:** _____

Approved by: _____ **Date Approved:** _____

2025 Sliding Fee Schedule

Maximum Annual income Amounts for each Sliding Fee Percentage Categary (except for 0% discount)

	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%
1	$15,060	$16,566	$18,072	$19,578	$21,084	$22,590	$24,096	$25,602	$27,108	$28,614
2	$20,440	$22,484	$24,528	$26,572	$28,616	$30,660	$32,704	$34,748	$36,792	$38,836
3	$25,820	$28,402	$30,984	$33,566	$36,148	$38,730	$41,312	$43,894	$46,476	$49,058
4	$31,200	$34,320	$37,440	$40,560	$43,680	$46,800	$49,920	$53,040	$56,160	$59,280
5	$36,580	$40,238	$43,896	$47,554	$51,212	$54,870	$58,528	$62,186	$65,844	$69,502
6	$41,960	$46,156	$50,352	$54,548	$58,744	$62,940	$67,136	$71,332	$75,528	$79,724
7	$47,340	$52,074	$56,808	$61,542	$66,276	$71,010	$75,744	$80,478	$85,212	$89,946
8	$52,720	$57,992	$63,264	$68,536	$73,808	$79,080	$84,352	$89,624	$94,896	$100,168

For families/households with more than 8 persons, add $5,380 for each additional person.

*Based on the 2024 Federal Poverty Guidelines (FPG) for the 48 contiguous states and the District of Columbia.