# PROPERTY TAX ALLOWANCE

## PURPOSE

Mason General Hospital and Family of Clinics will allow a one-time tax adjustment annually for Mason County residents.

## PROCEDURE

Eligibility? Primary residence located in Mason County.

Amount Allowed? Up to total Mason County hospital district assessed taxes for Mason County residence for the current year to cover out of pocket hospital expenses. This adjustment is offered one-time per calendar year with a maximum of $250.00 per year.

This adjustment is for Mason County taxpayer's and legal dependents.

To receive the adjustment the application (attachment A) needs to be filled out within 90 days from the date service or within 90 days from date insurance process' and pay's on account/s. An account will become ineligible for the adjustment if the account/s process to a collection agency.

An adjustment will be allowed yearly for up to the total amount of assessed hospital district taxes on the **primary** residence, which must be located in Mason County, for a Mason County land owner for services provided to the family to cover **out of pocket expenses**. This adjustment will be made only after all insurance sources have paid all they will pay and will not result in a refund of any monies except those paid by the patient or guarantor. Those eligible for this adjustment must be the property owner whose main residence is in Mason County or qualify as a dependent to that property owner and be claimed as such for income tax purposes.



Effective Date: 1/11/2010
Review Date: 6/1/2015
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Formulated Date: 11/1/2009

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To receive this adjustment, the patient or guarantor must complete Attachment A and present a copy of their current year tax statement for their primary residence in Mason County to the patient accounts representative Monday thru Friday 8AM to 5:30PM. The copy of the tax statement will remain a part of the adjustment record and must be attached to the adjustment form.



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Attachment A

MASON GENERAL HOSPITAL
P.O. BOX 1668
SHELTON, WA 98584

Application for tax adjustment for Mason County resident/family

Name of Mason County Taxpayer_____

Name of patient who received services_____

Address of **primary** residence of taxpayer/patient.

_____
Street City State

List **all** family members and their relationship to taxpayer who qualify as dependents:

_____
_____
_____
_____

My primary residence is located in Mason County. I am presenting my tax statement as proof of my assessed hospital district taxes for current year _____ and
Enter Year

I request that my bill be adjusted by _____ as set forth in hospital
Enter adjustment amount

policy for tax adjustment. I understand any and all insurance benefits due for my services, whether billed by me or the hospital, must be applied before I may take advantage of this adjustment.

_____
Signature of Taxpayer/Dependent Date



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