UW Medicine

Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as charity care) at UW Medicine. Washington State requires all hospitals to provide financial assistance to people and families who meet certain income requirements. You may qualify for financial assistance based on your family size and income, even if you have health insurance. Assistance is awarded if you meet the financial assistance guidelines which includes your household income is 300% or less of the federal poverty level. You can request more information or refer to our financial assistance website at www.uwmedicine.org/financialassistance or www.valleymed.org/financialassistance.

What does financial assistance cover? The hospital financial assistance covers appropriate hospital-based services provided by UW Medicine depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

In order for your application to b e processed, you must:

- Provide us information about your family; fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- Provide us information about your family's gross monthly income (income before taxes and deductions)
- Provide documentation for family income and declare assets
- Attach additional information if needed, for example, letters of support to validate your information
- Sign and date the form

Harborview Medical Center Financial Counseling 325 9th Ave; Mail Stop 359758 Seattle, WA 98104-2499 206.744.3084 FAX 206.744.5187 M-F 8:00 a.m. – 4:30 p.m.	**UW Medical Center-Montlake** Financial Counseling 1959 NE Pacific Street Mail Stop 356142 Seattle, WA 98195-6142 206.744.3084 FAX 206.598.1122 M-F 8:00 a.m. – 4:30 p.m.	**UW Medical Center-Northwest** Financial Counseling 1550 N 115th St Seattle, WA 98133-9733 206.744.3084 M-F 8:00 a.m. – 4:30 p.m.
Harborview Medical Center **UW Medical Center** Patient Financial Services 10330 Meridian Ave. N Suite 260 Seattle, WA 98133 206.598.1950 or 1.877.780.1121 M-F 8 a.m. – 4:30 p.m.	**Valley Medical Center** Patient Financial Services 3600 Lind Ave SW, Suite 110 Renton, WA 98057-4970 425.690.3578 FAX 425.690.9578 M-F 8:00 a.m. – 5:00 p.m.	**UW Physicians** **UW Neighborhood Clinics** Patient Accounts & Inquiry P.O. Box 50095 Seattle, WA 98145-5095 206.520.9300 or 1.855.520.9300 FAX 206.520.3200 M-F 9:00 a.m. – 5:00 p.m.
Harborview Medical Center **UW Medical Center** Patient Financial Services P.O. Box 95459 Seattle, WA 98145-2459 206.598.1950 or 1.877.780.1121 FAX 206.598.2360 M-F 8:00 a.m. – 4:30 p.m.	**Valley Medical Center** Patient Financial Services P.O. Box 59148 Renton, WA 98058-2148 425.690.3578 FAX 425.690.9578 M-F 8:00 a.m. – 5:00 p.m.	**Airlift Northwest** Patient Financial Services 6505 Perimeter Road S., Ste 200 Seattle, WA 98108 206.598.2912 FAX 206.521.1612 M-F 8:00 a.m. – 5:00 p.m.

If you have questions and need help completing this application please contact the facility above where you are seeking care. You may obtain help for any reason, including disability and language assistance. We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income. By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly! You may receive bills until we get your information.

UW Medicine

Financial Assistance Application Form – confidential

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION
Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*
Has the patient applied for Medicaid? □ **Yes** □ **No** *May be required to apply before being considered for financial assistance*
Does the patient receive state public services such as TANF, Basic Food, or WIC? □ **Yes** □ **No**
Is the patient currently homeless? □ **Yes** □ **No**
Is the patient's medical care need related to a car accident or work injury? □ **Yes** □ **No**

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION

Patient First Name	Patient Middle Name	Patient Last Name	
☐ Male ☐ Female ☐ Other (may specify _____)	Medical Record Number (MRN)	Patient Birth Date	Patient Social Security Number (optional)
Person Responsible for Paying Bill (Guarantor)	Relationship to Patient	Guarantor Birth Date	Guarantor Social Security Number (optional)
Mailing Address _____ _____ City State Zip Code			Main Contact Numbers ( ) _____ ( ) _____ Email address: _____

Employment Status of Person Responsible for Paying Bill
☐ **Employed** (date of hire:) ☐ **Unemployed** (how long unemployed:)
☐ **Self Employed** ☐ **Student** ☐ **Disabled** ☐ **Retired** ☐ **Other** (_____)

FAMILY INFORMATION

List family members in your household, **including yourself.** "Family" includes people related by birth, marriage, or adoption who live together and are claimed as dependents on your most recently filed federal income tax return.

FAMILY SIZE_____ *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:
- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (*please explain*_____)

UW Medicine

Financial Assistance Application Form – confidential

INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application.*

You must provide information on your family's income. Income verification is required to determine financial assistance.
All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. 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
- Bank Statements (3 months); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others (letter of support) stating your current financial situation and circumstances if you have no proof of income; or
- Forms approving or denying eligibility for Medicaid and/or state-funded medical assistance; or
- Forms approving or denying unemployment compensation; or written statements from employers or welfare agencies.

EXPENSE INFORMATION *(Please attach another page to list out other debts, if needed.)*

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*)

ASSET INFORMATION

Current Checking Account Balance $_____ Current Savings Account Balance $_____	Does your family have these other assets? **Please check all that apply** □ Stocks □ Bonds □ 401K □ Health Savings Account(s) □ Trust(s) □ Property (excluding primary residence) □ Own a business

ADDITIONAL INFORMATION

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, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that UW Medicine 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 information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.

_____ _____
Signature of Person Applying Date