MultiCare

# 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**

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<br>□ Other (may specify _____) | Birthdate | | Account # |
| Person Responsible for Paying Bill | Relationship to Patient | Birthdate | Social Security # *(optional)* |
| Mailing Address<br>_____<br>_____<br>City State Zip Code | | | Main contact number(s)<br>( ) _____<br>( ) _____<br>Email Address:<br>_____ |

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 you. "Family" includes people related by birth, marriage or adoption who live together.

**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 |

**Please check the location of the facility that you were seen:**

- ❑ MultiCare Puget Sound Hospitals
- ❑ MultiCare Puget Sound Clinics
- ❑ MultiCare Inland Northwest Hospitals
- ❑ MultiCare Rockwood Clinics
- ❑ Woodcreek Pediatrics
- ❑ ABC Clinics
- ❑ Olympic Sports and Spine
- ❑ MultiCare Behavioral Health Network

* *MultiCare Immediate Clinics, MultiCare Indigo Urgent Care and MultiCare Urgent Care Clinic visits are no longer covered under MultiCare's financial aid program.*

# FINANCIAL ASSISTANCE APPLICATION FORM – CONFIDENTIAL (cont.)

## INCOME INFORMATION

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

**You must provide information on your family's income. 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*_____*)*

**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
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for unemployment compensation.

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

## 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 MultiCare Health System 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