Charity Care/Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as charity care) at Virginia Mason.

Washington State requires all hospitals to provide financial assistance to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance. Virginia Mason approves charity at 300% of the Federal Poverty Guideline (FPG).

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

If you have questions or need help completing this application: Please contact Patient Account Services at 206.223.6601. You may obtain help for any reason, including disability and language assistance.

In order for your application to be 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**
- □ **Sign and date the form**

Note: **You do not have to provide a Social Security number to apply for financial assistance**. If you provide us with your Social Security number it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

Mail or fax completed application with all documentation to: Virginia Mason P.O Box 24163 Seattle, WA 98124 or fax to 206.515.5803. Be sure to keep a copy for yourself.

To submit your completed application in person: Please visit one of our Financial Navigators at our main campus or Regional Medical Centers.

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 receive your information.

Virginia Mason

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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 _____)	Birth Date		Social Security Number (optional*) **optional, but needed for more generous assistance above state law requirements*
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional*) **optional, but needed for more generous assistance above state law requirements*
Mailing Address _____ _____ City State Zip Code			Main contact number(s) ( ) _____ ( ) _____ 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 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

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_____)*

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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
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; 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.

EXPENSE INFORMATION

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

This information may be used if your income is above 101% of the Federal Poverty Guidelines.

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 Virginia Mason 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 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

Financial Assistance at Virginia Mason:

In furtherance of its charitable purpose, Virginia Mason is committed to providing emergency and medically necessary care to all persons in need of such care regardless of their ability to pay. Virginia Mason shall provide financial assistance to eligible patients in keeping with federal and state law. If you are having trouble paying for all or some of your health care, we encourage you to talk with a Virginia Mason Financial Navigator or someone in our business office about how we can help you.

What Is Covered? For emergency and medically necessary services at Virginia Mason, we provide financial assistance to eligible patients, with discounts based on ability to pay.

How to Apply? Any patient may apply to receive financial assistance. A patient seeking financial assistance must provide supporting documentation specified in the application. The application form may be obtained online, by telephone, or from the website or email addresses noted below.

Other Assistance:
Coverage assistance: If you are without health insurance, you may be eligible for government or other community programs. We can help you discover whether these programs (including Medicaid) can help cover your medical bills. We also can help you apply for these programs.

Uninsured Discounts: Virginia Mason offers a 35% discount for patients who may not have health insurance coverage.

Payment plans: Any balance for amounts owed by you is due within 28 days from receiving a Virginia Mason statement. The balance can be paid in any of the following ways: cash, check, credit card, online bill pay or a payment plan. If you need a payment plan, please call the number on your billing statement to make arrangements.

Emergency Care: The Virginia Mason dedicated emergency department provides care for emergency medical conditions (as defined by the Emergency Medical Treatment and Labor Act) without discrimination and without regard to whether or not a patient has the ability to pay or is eligible for financial assistance.

Contact Us for Financial Assistance Help or Applications
For more information about getting help with your Virginia Mason medical bills, please call or visit a financial navigator or billing office at your local Virginia Mason facility. We can give you any forms you need and can help you apply for assistance. Patients are strongly encouraged to ask for financial help before receiving medical treatment, if possible. Patients can also apply at any time while receiving treatment and for a period of time following receipt of your initial bill.

If you have questions or would like to receive a financial assistance application form, please contact us by:

- Telephone: (206) 223-6601 or (800) 553-7803
- Email: VMMC.billing@virginiamason.org
- Website at: http://www.virginiamason.org