REQUEST FOR FINANCIAL ASSISTANCE

Dear Patient and Family:

In keeping with its mission and core values, Providence Health & Services (PH&S) is committed to providing health care for people regardless of their ability to pay.

**PH&S Financial Assistance** - Medical bills may be difficult to pay. Patients who do not have health insurance and who are unable to pay for all or part of their health care services may apply for financial assistance by completing and returning a Financial Assistance Application (FAA).

**Options Available** - PH&S will work with patients to see if they qualify for Medicaid, Medicare, private insurance, interest free payment plan options, or financial assistance. If financial assistance is granted, some or all PH&S charges may be lowered.

**Application Process** - To apply for financial assistance, please complete and return a completed FAA form, together with supporting information to:

Providence Regional Medical Center Everett
Attention: Financial Counseling
PO BOX 1147
Everett, WA 98206-9936

**Supporting Information** - the following supporting information must be included with the FAA form:

- Most recent **Federal Tax Returns** – Form 1040 and if self employed add Schedule C documentation.
- Copies of the most recent **income information for each person in the household** including pay stubs, Social Security, unemployment, retirement, pensions, etc.
- If the household is receiving financial support from family or friends, provide a letter detailing the support from the assisting party. PH&S may also request proof of income depending on the level and duration of support.
- Copy of your **most recent bank statements** (showing balance and activity for the last 60 days).

**Without the above listed items, PH&S will be unable to process the application.**

**Questions?** – If you have any questions please call our customer service department at:

(425) 261-4002 Monday – Friday 7:30 a.m. to 4:00 p.m.

The completed FAA form (together with supporting information) should be returned to PH&S within 14 days of receipt.

By submitting applications for assistance, patients give PH&S consent to make all necessary inquiries to confirm financial obligations or references.

Sincerely,

Financial Assistance Team
Providence Health & Services

*Providence Health & Services strives to provide excellent service for your health care needs.*
REQUEST FOR FINANCIAL ASSISTANCE

I. Patient Information

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MI</th>
<th>ACCOUNT #</th>
<th>DATE OF SERVICE</th>
<th>SOCIAL SECURITY NUMBER</th>
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<thead>
<tr>
<th>ADDRESS</th>
<th>STREET</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
<th>HOME TELEPHONE</th>
<th>WORK</th>
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DATE OF BIRTH

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<tr>
<th>PRIMARY CARE PHYSICIAN (PCP)</th>
<th>U.S. CITIZEN</th>
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I. Guarantor Information

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<tr>
<th>NAME OF PERSON RESPONSIBLE FOR PAYING THE BILL</th>
<th>RELATIONSHIP</th>
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<th>ADDRESS</th>
<th>STREET</th>
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<tr>
<th>TELEPHONE NUMBER</th>
<th>HOME</th>
<th>WORK</th>
<th>U.S. CITIZEN</th>
<th>DATE OF BIRTH</th>
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Please check this box if you have not received services and are applying to pre-qualify.

Have you been approved for Financial Assistance by another Health Care organization? ☐ YES ☐ NO

If yes, please provide name of organization _______________________________________________________________________________

Are you being referred by a physician or surgeon? ☐ YES ☐ NO

If yes, please provide name and phone of number of physician ________________________________________________________________

III. Household Information

Please list anyone living in your household (including yourself). Income includes (pre-tax) wages, child support income, alimony income, rental income, unemployment compensation, social security benefits, public/government assistance, rent or living expenses exchanged for services provided, etc.

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<thead>
<tr>
<th>HOUSEHOLD MEMBERS</th>
<th>AGE</th>
<th>RELATIONSHIP TO PATIENT</th>
<th>SOURCE OF INCOME OR EMPLOYER NAME</th>
<th>MONTHLY GROSS INCOME PRIOR TO DATE OF SERVICE</th>
<th>INSURED? (circle yes or no)</th>
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IV. Expenses and Assets

Rent ___________________________________________________ Recreational vehicles _____________________________________

Mortgage payment ____________________________ Send proof Health insurance premiums ________________________________

Mortgage balance ____________________________ Send proof Stocks, bonds, retirement accounts, etc. ______________________

Cost of utilities __________________________________________ Monthly child care ______________________________________

Checking account balance ______________________________ Real estate other than primary home _________________________

Savings account balance __________________________________ Other assets ____________________________________________

Car payment ____________________________________________ ______________________________________________________________________

Year and make of vehicle __________________________________ ______________________________________________________

Are you a full time student? _______________ Please send student loan report.

Do you receive any form of public assistance (food stamps, HUD housing, etc.) ________________ If yes, please send proof.

Monthly costs of medications or medical supplies ____________________________________________

Are you being supported by a parent or other person?

If yes, please provide income and tax information of the person supporting you.

If you need to write a letter explaining your individual situation please attach it to this form.

V. Required Information – Must be included with this application

Please check that you have included the following:

☐ Copy of previous year’s tax returns
☐ Copy of latest bank statement
☐ Income verification showing earnings or pay stubs for all income year to date

Additional information may be required in order to process your application. If so, we will contact you.

VI. Authorization

I hereby certify the information contained in the above financial questionnaire is correct and complete to the best of my knowledge. I authorize Providence Health & Services to verify any or all information given and understand that a credit report may be run as part of this verification process.

X

RESPONSIBLE PERSON’S SIGNATURE DATE

Providence Health & Services strives to provide excellent service for your health care needs.