

*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? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <i>If Yes, list preferred language:</i>
Has the patient applied for Medicaid? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Does the patient receive state public services such as TANF, Basic Food, or WIC? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Is the patient currently homeless? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Is the patient's medical care need related to a car accident or work injury? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>

### 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
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (may specify _____)	Birthdate	Account #
Person Responsible for Paying Bill	Relationship to Patient	Birthdate
Social Security # (optional)		
Mailing Address _____ _____		Main contact number(s) ( ) _____ ( ) _____
City	State	Zip Code
Email Address: _____		
Employment status of person responsible for paying bill <input type="checkbox"/> <b>Employed</b> (date of hire: _____) <input type="checkbox"/> <b>Unemployed</b> (how long unemployed: _____) <input type="checkbox"/> <b>Self-Employed</b> <input type="checkbox"/> <b>Student</b> <input type="checkbox"/> <b>Disabled</b> <input type="checkbox"/> <b>Retired</b> <input type="checkbox"/> <b>Other</b> ( _____ )		

### 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:**

- |   |  |
|---|--|
| <input type="checkbox"/> MultiCare Puget Sound Hospitals      | <input type="checkbox"/> Woodcreek Pediatrics                |
| <input type="checkbox"/> MultiCare Puget Sound Clinics        | <input type="checkbox"/> ABC Clinics                         |
| <input type="checkbox"/> MultiCare Inland Northwest Hospitals | <input type="checkbox"/> Olympic Sports and Spine            |
| <input type="checkbox"/> MultiCare Rockwood Clinics           | <input type="checkbox"/> 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