CONFIDENTIAL FINANCIAL INFORMATION FORM

UW Medicine

It is the policy of UW Medicine to grant Charity Care to eligible persons for medically necessary services. Eligible persons are defined as residents of Washington State as described in WAC 388-468-0005, who are at or near the federal poverty level. In order for your request to be processed timely, your completed application and requested documentation must be received by the Due Date indicated on the top left of the Confidential Financial Information Form (within 15 business days from the date of application). The information on this form will be used to determine your eligibility for Charity Care. If you are not eligible for Charity Care, payment arrangements may be an option.

INSTRUCTIONS:

Please fill out the Confidential Financial Information Form completely. Make sure you sign and date the form.
If an item does not apply, write N/A (not applicable).

Please provide the information requested below by the checked boxes for you and your spouse:

- ☐ **Pay Stubs or Earnings Statements for the past 2 months**
  (if you do not have the check stubs, we will accept a signed letter from your employer with this information)
- ☐ **Other Gross Income** *(DSHS Assistance Income, VA Benefits, Workers Compensation, Rental Income)*
- ☐ **Pension / Retirement / Social Security Income Interest Income from Stocks, IRAs, CDs, etc.**
- ☐ **Self-Employment Taxes** *(last return filed)* **including supporting documentation**
- ☐ **Unemployment Benefits:** Obtain the "Work History Benefits Form" from Work Source
  You can obtain this verification from: 2531 Rainier Ave. South; phone: 206-721-6000 or 2550 Aurora Ave. North; phone: 206-440-2500
- ☐ **Checking and Savings Statements for the past 2 months for ALL accounts**
- ☐ **Debts** *(section on application)* **include balances outstanding at any UW Medicine facility** *(reference facility name, amount, account no.)*
- ☐ **Medicaid Application / Denial Letter**
- ☐ **Letter of Support:** Attach a letter stating your financial situation and circumstances. If you are living with friends, relatives, or staying at one of the missions/shelters, please have them write and sign a statement regarding the type of help they are providing for you. If applicable, UW Medicine will rely upon written and signed statements regarding income.
- ☐ **Other Information:** _____

NOTE: Additional documentation may be required to complete the Charity Care process.

» **IF DOCUMENTATION IS NOT ATTACHED OR IS INCOMPLETE, YOUR CONFIDENTIAL FINANCIAL FORM CANNOT BE PROCESSED. IF YOU HAVE ANY FURTHER QUESTIONS REGARDING THE FORM OR THE INFORMATION REQUIRED; OR WOULD LIKE TO CHECK ON THE STATUS OF YOUR REQUEST, PLEASE CONTACT THE UW MEDICINE FACILITY THAT IS CHECKED BELOW. WE WILL BE HAPPY TO ASSIST YOU.**

☐ **Harborview Medical Center (HMC)**
Financial Counseling
325 9th Ave; Mail Stop 359758
Seattle, WA 98104.2499
206.744.3084
M-F 8:00 a.m. – 4:30 p.m.

☐ **University of Washington Medical Center (UWMC)**
Financial Counseling
P.O. Box 359412
Seattle, WA 98195
206.598.1950 or 1.877.780.1121
M-F 8:00 a.m. – 4:30 p.m.

☐ **HMC & UWMC**
Patient Financial Services/Billing Office
Box 95459
Seattle, WA 98145-2459 ***206.598.1950 or 1.877.780.1121***
M-F 8:00 a.m. – 4:30 p.m.

☐ **Northwest Hospital (NWH)**
Patient Financial Services
10330 Meridian Ave N Ste 260
Seattle, WA 98133-9851
206.368.6440 or 1.877.364.6440
M-F 8:00 a.m. – 4:30 p.m.

☐ **University of Washington Physicians (UWP) & UWNC**
P.O. Box 50095
Seattle, WA 98145-5095
206.543.8606 or 1.888.234.5467
M-F 9:00 a.m. – 5:00 p.m.

☑ **Valley Medical Center (VMC)**
Patient Financial Services
PO Box 59148
Renton, WA 98058-9900
425.251.5178 FAX 206.575.2573
M-F 8:00 a.m. – 5:00 p.m.

» **PLEASE USE THE ENCLOSED SELF-ADDRESSED STAMPED ENVELOPE TO RETURN YOUR COMPLETED CONFIDENTIAL FINANCIAL INFORMATION FORM AND SUPPORTING DOCUMENTATION**

» **NOTICE TO PATIENTS REQUESTING CHARITY ASSISTANCE:**
To provide you a decision on your charity application, we may access information in a Consumer Credit Report from a credit reporting company for a "soft inquiry". This inquiry will not negatively affect your credit or your credit score and is only visible to you. The legal requirements under 604 of the Fair Credit Reporting Act prohibits us from sharing this information for any purpose.

DATE PROVIDED/MAILED: _____ DATE DUE: _____

CONFIDENTIAL FINANCIAL INFORMATION

UW Medicine

☐ HARBORVIEW MEDICAL CENTER ☐ UNIVERSITY OF WASHINGTON MEDICAL CENTER ☐ HMC & UWMC PATIENT FINANCIAL SERVICES ☐ NORTHWEST HOSPITAL ☐ UNIVERSITY OF WASHINGTON PHYSICIANS & UWNC ☑ VALLEY MEDICAL CENTER

INSTRUCTIONS: When completing this form, it is necessary that you fill in all blanks and attach any supporting documentation as may be required to substantiate gross income and assets.

NAME
ACCOUNT NUMBER

GUARANTOR					
FULL NAME — LAST	FIRST				MIDDLE
PERMANENT ADDRESS — STREET	CITY		STATE	ZIP CODE	PHONE
OCCUPATION	PRESENT EMPLOYER'S NAME				

ASSETS

CHECKING ACCOUNT		
BANK NAME AND BRANCH	ACCOUNT NO.	BALANCE $
SAVINGS ACCOUNT		
BANK NAME AND BRANCH	ACCOUNT NO.	BALANCE $
OTHER ASSETS		
$		

MONTHLY GROSS INCOME

GUARANTOR'S GROSS INCOME	$
GUARANTOR'S SPOUSE'S INCOME	$
OTHER GROSS INCOME	$
TOTAL GROSS INCOME	$

FAMILY SIZE

TOTAL NUMBER OF FAMILY MEMBERS	AGES OF CHILDREN LIVING AT HOME

RESIDENCE

☐ RENTING ☐ BUYING	MONTHLY PAYMENT		IF BUYING HOME, WHAT IS THE:	MARKET VALUE $	BALANCE DUE $

DEBTS

NAME OF CREDITOR	MONTHLY PAYMENT	BALANCE DUE
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$

In completing this financial statement, I hereby affirm that the above statements are correct and complete, including any supporting documentation I have been asked to provide. I understand a system that estimates income may be used, which is based on information contained in a Consumer Credit Report, to validate my stated income. I give my consent to further verification by UW Medicine or their agents.

Signature of Guarantor _____ Date _____

Signature of Guarantor's Spouse _____ Date _____

SAVE