Financial Assistance Application Form Instructions

Washington State requires all hospitals to provide financial assistance to individuals and families who meet certain income requirements. You may qualify for financial assistance based on your family size and income, even if you have health insurance. Valley Medical Center & Clinics provides financial assistance for any patient/guarantor whose gross family income is up to 400% of the Federal Poverty Level (FPL) and adjusted for family size after any third-party coverage has been exhausted. For facility and/or professional services at Valley Medical Center & Clinics:

- 0% - 300% of the FPL for a 100% financial assistance discount

- For facility services only with discharge dates on or after July 1, 2022, at Valley Medical Center & Clinics:
  - 301% - 350% of the FPL for a 75% financial assistance discount
  - 351% - 400% of the FPL for a 50% financial assistance discount

What does financial assistance cover? The financial assistance policy covers appropriate hospital-based (facility) and non-hospital-based (professional) services provided by Valley Medical Center & Clinics depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations. You can request more information or refer to our website at valleymed.org/financialassistance.

In order for your application to be processed, you must: Provide us information about your family tell us the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)

- Provide your family's gross monthly income (before taxes and deductions)
- Provide documentation for family income and provide a declaration of assets
- Attach additional information if needed, for example, letters of support to validate your information
- Sign and date the form

For the Financial Assistance Application and supporting documents in English or Spanish, you can now utilize MyChart to submit your documents based on your care location. For all other application submissions continue to submit by mail, fax, or in person. Any information submitted for consideration will be treated as protected health information under the Health Insurance Portability and Accountability Act (HIPAA).

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."

To process your application, you must be a registered patient with a Medical Record Number (MRN):

Valley Medical Center & Clinics Patient Financial Services P.O. Box 59148 Renton, WA 98058-2148 Phone 425.690.3578 FAX 425.690.9578 M-F 8:00 a.m. – 5:00 p.m. mychart.valleymed.org/#mychart	Valley Medical Center & Clinics Patient Financial Services 3600 Lind Ave SW, Suite 110 Renton, WA 98057-4970 Phone 425.690.3578 FAX 425.690.9578 M-F 8:00 a.m. – 5:00 p.m. mychart.valleymed.org/#mychart

Please contact Patient Financial Services if you have questions and need help completing this application. You may obtain help for any reason, including disability and language assistance. 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 to make necessary inquiries to confirm the information.

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Financial Assistance Application Form – confidential

Please fill out all information completely. If it does not apply, check "No" or 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 currently have health insurance? ☐ **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 ☐ Other (may specify _____)	Medical Record No. (MRN)	Patient Birth Date	Patient Social Security No. (optional)
Person Paying Bill (Guarantor)	Relationship to Patient	Guarantor Birth Date	Guarantor Social Security No. (optional)
Mailing Address _____ _____ City State Zip Code			Area Code Phone Numbers (_____) _____ (_____) _____ Email address:

Employment Status of Person 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 yourself.** "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 - SSI - Unemployment - Self-employment - Worker's compensation - Disability - 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
- Bank Statements (3 months); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others (letter of support) stating your current financial situation and circumstances if you have no proof of income; or
- Forms approving or denying eligibility for Medicaid and/or state-funded medical assistance; or
- Forms approving or denying unemployment compensation; or written statements from employers or welfare agencies.

MONTHLY EXPENSE INFORMATION *(Please attach another page to list out other debts, if needed.)*

We use this information to get a more complete picture of your financial situation.

Rent/Mortgage $

Insurance Premiums $

Other Debt/Expenses $ *(child support, loans, medications, other)*

Medical Expenses $

Utilities $

ASSET INFORMATION (*not considered for financial assistance qualification but is used for other programs)*

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 that Valley Medical Center & Clinics 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.

Name of Person Applying

Date