EVERGREEN
HEALTHCARE 12040 NE 128th Street • Kirkland, WA 98034-3098

Application for Charity Care

Evergreen Healthcare encourages you to apply for Charity Care if you are low income and need help paying hospital charges for inpatient or outpatient care. Charity Care may offer either free care or reduced-price care based on your eligibility and income. ***If you have questions or need help completing this application, please call Healthcare Access at (425) 899-3200.***

Patient Name	Date of Birth	Social Security No.	Marital Status

If patient is a minor or a dependent print name of parent or responsible party.	Relationship to Patient	Home Phone	Work Phone

Address	City/State	Zip Code

Number of people in family (living in household): _____

Note: "Family" means a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as members of one family. [WAC 246-453-001 (18)]

Health Insurance Information

Medical Insurance? Yes_____ No_____ If "yes," print name of insurance company: _____

_____

Policy Number: _____ Other Coverage? Yes_____ No_____

Please identify other coverage: _____ Medicare_____ Medicaid_____

Is the medical treatment because of a car accident or other third party injury? Yes_____ No_____

Is the medical treatment because of an on-the-job injury or accident? Yes_____ No_____

Income Information:

Note: "Income" means total cash receipts before taxes derived from wages and salaries, welfare payments, social security payments, strike benefits, unemployment or disability benefits, child support, alimony and net earnings from business and investment activities paid to the individual. [WAC 246-453-001 (17)]

Be sure to include with your application documents that give the income amounts you list below. For example:

- Pay stubs from all employment or
- A "W-2" withholding statement or
- Last year's income tax return or
- Letters approving or denying Medicaid, medical assistance, other benefits or
- Letters approving or denying unemployment compensation or
- Written statements from employers or welfare agents.

CURRENT MONTHLY INCOME (before taxes are taken out)

Patient and/or Responsible Party $_____ Source _____

Spouse $_____ Source _____

Alimony/Child Support $_____ Source _____

Other $_____ Source _____

TOTAL CURRENT MONTHLY INCOME: $_____

Note: Income declared should match supporting documentation.

Please turn page over and complete other side. ***(Your signature is required where indicated on back.)***

ASSETS

Note: Information will be used if you fall within 101% -400% of poverty guideline.

Value of Bank Accounts – Checking $ _____ **Value of Investments –** IRA/Retirement Accounts/Stocks Securities

Savings $ _____ $ _____ Describe _____

MONTHLY EXPENSES (Use a separate sheet of paper to list more expenses.)

Housing $ _____ Rent Own (Please circle one) Medical Bills $ _____

Utilities $ _____ Other $ _____

Food $ _____ Describe _____

Has your family had any seasonal or temporary increases or decreases in income? Or, do you expect your income to change in the next three months?

Yes_____ No_____ If "yes," please describe: _____

_____

_____

Have you recently suffered severe financial hardship or personal loss (for example, other medical expenses, death of a loved one, loss of job or wages, loss of home, auto, or other property)?

Yes_____ No_____ If "yes," please explain: _____

_____

_____

Do the documents that you are including with this application show your current financial situation correctly?

Yes_____ No_____ If no, why not? _____

_____

If you are asking for Charity Care for services already provided by Evergreen Healthcare, please list dates of services and what services you received:

_____

_____

I understand that the information I am giving will be verified by Evergreen Healthcare and reviewed by state and/or federal enforcement agencies and others as required. Evergreen Healthcare reserves the right to access my credit information to assist in determining patient eligibility for financial-assistance programs. I certify that the above information is true and accurate to the best of my knowledge.

Signature _____ **Date** _____

Mail this application with all documentation to:

Evergreen Healthcare Attn: Patient Financial Services
12040 NE 128th Street
Kirkland, WA 98034-3098
