Business Services Department

Financial Hardship Assistance (FHA) Application

Please mail completed form to:

The Everett Clinic
Part of Optum®

THE POLYCLINIC
Part of Optum®

Attention: Customer Service Department

PO Box 3753 | Seattle, WA 98214-5752 | (425) 258-3900

FHA Application instructions

STEP 1: Complete patient information. Please fill out all information concerning the patient completely

STEP 2: Fill out income information. This includes income from your employer, social service aid (food stamps, ADC, General Relief), government aid (social security, VA benefits), and all other income. If any child is 18 years or older, a separate form is required

STEP 3: Fill out monthly expenses and liabilities. This includes mortgage payment, rent, utilities, medical, or other expenses.

STEP 4: Return to Business Office (at address above) via mail, or walk-in, with original signature on application and supporting documentation.

IN ORDER FOR THE EVERETT CLINIC AND THE POLYCLINIC TO COMPLY WITH STATE GUIDELINES, **EACH ITEM YOU HAVE LISTED ON THE FRONT OF THIS APPLICATION WILL REQUIRE PROOF OR DOCUMENTATION**. ALL INFORMATION MUST BE RETURNED WITHIN **30 DAYS** OF INITIAL REQUEST FOR FINANCIAL ASSISTANCE OR YOU MAY BE RESPONSIBLE FOR YOUR CHARGES.

The following are types of documentation needed. Please check each one to see which ones may apply to your situation: **(COPIES ONLY PLEASE,** originals will not be returned.)

- Most recent IRS tax forms (1040 and/or W-2) **Must Be Signed**
  AND Check stubs for the past 30 days for all persons employed in the home
- Unemployment check stubs for the past 30 days
- State or Federal issued identification card with photo or Driver's license for person applying. Identification is needed to ensure fraud protection.
- Proof of all other income received in the past 30 days (government benefits; SSI, VA, etc., alimony/spousal support, child support, investment revenue, settlements, etc.)
- If you currently do not have any form if income, please provide a letter advising of current financial support.
- Submit Mortgage / rent and utilities, and any outstanding medical bills.
- Attached FHA Application ***(completely*** filled out and signed)

- Have you been approved for financial hardship at another local hospital or medical facility within last 6 months? ______________________
- If so, which institution ______________________________. Can you provide documentation of approval?

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CONFIDENTIAL

STEP 1: COMPLETE INFORMATION BELOW (SEE REVISE SIDE FOR INSTRUCTIONS}

Medical Record Number ***(to be entered by FC)***		Social Security Number
Patient Name		Date of Birth
Address		Phone Number (Home)
City, State, Zip Code		Phone Number (Cell)

STEP 2: FILL OUT INCOME/ ASSET INFORMATION

If there is no reported income, explain your means of support

Dependents that contribute income to the household expenses (outlined below)

Self and Spouse/Partner	AGE	Relation to Patient	Gross monthly Income (Pre-Tax)

Family Members - living and support in the household	AGE	Relation to Patient

STEP 3: FILL OUT AVG MONTHLY EXPENSES & LIABILITIES INFORMATION

Mortgage/Rent:	Amount:
Total Utilities:	Amount:
Electric:	Amount:
Water:	Amount:
Gas:	Amount:
Medical:	Amount:
Other:	Amount:

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If unemployed, please provide the date employment was terminated: ___________________________

Do you have Medicaid? Yes / No   If yes, please provide copy of Medicaid card.

Have your ever applied for Medicaid? Yes / No

If yes, please list when and where:____

DECLARATION: THE INFORMATION PROVIDED ABOVE IS, TO THE BEST OF MY KNOWLEDGE AND BELIEF, COMPLETE, ACCURATE, AND TRUE. I AUTHORIZE THE RELEASE OF ALL INFORMATION WHICH THE EVERETT CLINIC AND THE POLYCLINIC MAY NEED TO DETERMINE WHETHER I QUALIFY FOR FINANCIAL ASSISTANCE THROUGH ITS INDIGENT CARE PROGRAM OR ANY OTHER FEDERAL OR STATE FUNDED MEDICAL ASSISTANCE PROGRAM (state dependent), INCLUDING THE VERIFICATION OF MY SALARY OR WAGES, THE BALANCE OF MY BANK ACCOUNTS THAT I MAINTAIN, THE CASH-IN VALUE OF ANY LIFE INSURANCE POLICY, STOCKS OR BONDS WHICH I POSSESS, AS WELL AS THE VALUE OF ANY REAL OR PERSONAL PROPERTY WHICH I OWN OR AM PURCHASING. SHOULD I BE REFERRED TO A FEDERAL OR STATE FUNDED MEDICAL ASSISTANCE PROGRAM I AUTHORIZE DAVITA MEDICAL GROUP TO RELEASE AND OBTAIN ALL INFORMATION NEEDED TO DETERMINE ELIGIBILITY FOR THAT FUNDING.

Applicant's Signature:______________________________________Date:____________________

The Everett Clinic and The Polyclinic, part of Optum, does not discriminate on the basis of sex, age, race, color, national origin, or disability.

Free services are available to help you communicate with us. Such as letters in other languages, or in other formats like large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free number 1-877-626-0678 TTY 711.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-877-626-0678.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電：1-877-626-0678。

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