OLYMPIC
MEDICAL CENTER

Financial Assistance Application
(Charity Care)

For additional information,
please contact Patient Financial Services:

Phone:	**In Person**:	**Mail**:
(360) 417-7111	519 S Peabody St.	939 Caroline St.
(800) 854-2844	Port Angeles	Port Angeles, WA 98362
(TTY: 1-360-417-8686)	Monday - Friday	
	8:00am to 4:30pm	

Olympic Medical Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish)	Olympic Medical Center cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-360-417-7000 (TTY: 1-360-417-8686).
繁體中文 (Chinese)	Olympic Medical Center 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-360-417-7000 (TTY: 1-360-417-8686)。

Financial Assistance Application (Charity Care) Instructions

This is an application for financial assistance (also known as charity care) at Olympic Medical Center

Washington State requires all hospitals to provide financial assistance to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance. Visit www.olympicmedical.org then go to Patients & Visitors, Billing & Financial Services

What does financial assistance cover? Financial assistance covers appropriate services provided by Olympic Medical Center and Olympic Medical Physicians depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

If you have questions or need help completing this application:
519 S Peabody St. Port Angeles, WA 98362 Phone: (360) 417-7111 (800) 854-2844
You may obtain help for any reason, including disability and language assistance.

In order for your application to be processed, you must:

- **Provide us information about your family**
  Fill in the number of family members in your household
  (family includes people related by birth, marriage, or adoption who live together)
- **Provide us information about your family's gross monthly income (income before taxes and deductions)**
- **Provide documentation for family income**
- **Attach additional information if needed**
- **Sign and date the form**

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."

Mail completed application with all documentation to: 939 Caroline St., Port Angeles, WA 98362.
Be sure to keep a copy for yourself.

To submit your completed application in person: 519 S Peabody St. Port Angeles, WA 98362. Mon - Fri 8:00am to 4:30pm
Phone: (360) 417-7111 (800) 854-2844

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 for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly!
You may receive bills until we receive your information.

Olympic Medical Center
Financial Assistance Application (Charity Care) – Confidential

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? ❑ **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 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 & 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 _____)	Birth Date	Patient Social Security Number *(Optional)*

Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number *(Optional)*

Mailing Address_____

City_____ State_____ Zip Code_____

Main contact number(s)
( ) _____
( ) _____
Email Address:_____

Employment status of person responsible for paying bill
❑ **Employed** (date of hire:_____) ❑ **Unemployed** (how long unemployed:_____)
❑ **Self-Employed** ❑ **Student** ❑ **Disabled** ❑ **Retired** ❑ **Other** (_____)

FAMILY INFORMATION

FAMILY SIZE _____

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together *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**
					❑ **Yes** ❑ **No**
					❑ **Yes** ❑ **No**

All adult family members' income must be disclosed. 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

Continue

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Please fill out all information completely.
If it does not apply, write "NA." Attach additional pages if needed.

PATIENT INFORMATION

Patient First Name	Patient Middle Name	Patient Last Name	Date of Birth

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. Please provide proof for every identified source of income.

Examples of proof of income include:

- A "W-2" withholding statement
- Current pay stubs (*3 months*)
- Last year's income tax return, including schedules if applicable
- Written, signed statements from employers or others
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance
- 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.

EXPENSE INFORMATION

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

Monthly Household Expenses:

Rent/mortgage $_____ Medical expenses $_____

Insurance Premiums $_____ Utilities $_____

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

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, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that Olympic Medical Center 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 financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

Signature of Person Applying:_____ Date _____