Financial Assistance Application Package

Dear Parent/Patient,

Overlake Medical Center provides financial assistance to those who qualify. Please follow the instructions below for consideration. If you have questions, please contact our financial assistance coordinator at 425.635.6239.

Washington State requires all hospitals to provide financial assistance to people and families who meet certain income requirements. You may qualify for free or reduced-price care based on your family size and income, even if you have health insurance. The financial assistance policy can be viewed at www.overlakehospital.org/financialpolicies.

What does financial assistance cover? The financial assistance covers appropriate services provided by Overlake Medical Center depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations, professional fees or elective procedures.

INSTRUCTIONS

IMPORTANT NOTICE: **Please download this document to your device before filling it out digitally. This is necessary for the "Submit Form" button (located at the end of this document) to work.**

1. Please complete all sections of the attached application, pages 2–5. If any section does not apply to you, write N/A in the space provided.
2. Attach an additional page if you need more space to answer any question.
3. If you are married, both you and your spouse are required to submit supporting documentation for your application, and both of you must sign and date the Certification and Authorization on page 5.
4. The following are required as support for your application:

a. Pay stubs for the last three months, for yourself and your spouse (if married).

b. Written verification of wages from your employers (and, if applicable, your spouse's employers) for the last three months.

c. Written verification from public assistance agencies for the last three months.

d. Forms approving or denying unemployment compensation and/or workers' compensation.

OR:

If you have no income, submit a letter explaining how you support yourself and your family.

PATIENT & FAMILY INFORMATION

Patient Account #	Patient Name
Responsible Party Name (if different from patient)	Spouse Name
Address	Phone Home: (______) ______ - _________ Work: (______) ______ - _________

Social Security Number(s) (required)

Responsible Party SSN	Spouse SSN (if married)

Family Size: List all dependents that you support.

Name	Age	Relationship

Employment Status

Responsible Party's Employer	Position
Spouse's Employer (if married)	Position

Continued ►

FINANCIAL INFORMATION		
Bankruptcy		
Have you filed for bankruptcy in the past 10 years? ☐ Yes ☐ No	If yes, give date of bankruptcy filing:	

Income	**Responsible Party**	**Spouse**
1. Gross Wages & Salary (before deductions)	$	$
2. Self-Employment INcome	$	$
3. Interest & Dividends	$	$
4. Real Estate Rentals & Leases	$	$
5. Social Security	$	$
6. Alimony	$	$
7. Child Support	$	$
8. Unemployment/Disability	$	$
9. Public Assistance	$	$
10. All Other Sources (attach list)	$	$
Total Income (add lines 1-10 above)	**$**	**$**

Monthly Expenses

List your monthly expenses. Provide information on any unusual expenses such as medical bills, court judgments or settlement payments, etc. Attach documentation to support unusual expenses.

Description	**Amount**
Rent/Mortgage	$
Car(s)	$
Car Insurance	$
Boat/RV	$
Credit Card(s)	$

Continued ►

Description	Amount
Electricity/Gas	$
Water	$
Telephone(s)	$
Groceries	$
Health/Dental Insurance	$
	$
	$
	$
	$
	$
	$
	$
	$

Continued ►

Certification and Authorization

Patient Name: ____

Patient Account Number: ____________________________________

Responsible Party's Name: __________________________________

Spouse's Name (if married): _________________________________

I/we hereby apply for financial assistance for services rendered by **Overlake Medical Center**.

In the event the undersigned, the patient, or any other persons on the patient's behalf are entitled to receive insurance benefits because of services rendered to the patient by Overlake Medical Center, the insurance benefits will be assigned to Overlake Medical Center for application against the patient's bill

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize the Provider to verify any information listed in this application. This includes authorization for Overlake Medical Center to request a Credit Bureau Report to verify my/our financial standing.

___________________________________	___________________________________
Signature of Responsible Party	Signature of Spouse (if married)
___________________________________	___________________________________
Date	Date

You may also save your form and send via email to **charitycare@overlakehospital.org.**

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