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 425.688.5124.

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:

   Proof of income: Copy of current Federal Tax Return, unemployment benefits
   OR one of the following:

   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. Mail, fax or email the completed application with income documentation to:

   Overlake Medical Center
   Attn: Patient Financial Services
   1035 116th Ave NE
   Belleve, WA 98004

   Fax: 425.688.5658
   Email: charitycare@overlakehospital.org

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.**

Submit Form