SWEDISH MEDICAL CENTER

To be considered for financial assistance you must provide the following:

1. The completed and signed Financial Questionnaire
2. Copy of your most recent bank statement (Showing balance and activity for at least 60days)
3. Copy of your previous year's Federal Tax Return
4. Copies of your 2 most recent pay stubs to validate household income. (If you are self employed, provide copies of three months Profit and Loss Statements)
5. Supporting documentation of all forms of income. For example; public assistance award or denial letters, alimony court orders
6. Verification of Investment Value(s) (Stocks, Bonds, Mutual Funds, IRA, CD, 401K, Trust Funds, etc. Please verify the amount of monthly income (if any) drawn from investments
7. If you are claiming no income or there has been a recent change in your financial situation you must include a letter of explanation. If someone else is paying for your food and shelter please include a letter of explanation from them. Also, please verify that you have no source of income and how long it has been since you have not had a source of income. Examples of verification may include but are not limited to: Current Tax Return, letter from a professional business, bank statements showing no deposits/withdrawals, Medicaid determination letter, etc.

Applications **must** be returned within **14** days or requests may be denied. Please note that if financial assistance is granted it will only cover your medical bills from our facility. It will not apply to the bills for other medical groups, hospitals, or physicians groups unless they specifically agree to accept it. **PLEASE CONTACT THE OTHER MEDICAL GROUPS DIRECTLY TO INQUIRE ABOUT ASSISTANCE OPTIONS.**
When applying for financial assistance you are giving consent for us to make necessary inquiries to confirm financial obligations or references.

Questions: Please contact our Customer Service Center; open Monday-Friday, 8 a.m.to 5 p.m. at 206-320-5300 or 877-406-0438 outside of the local calling area.

Return To: Swedish Medical Center
Attn: Corporate Business Office
747 Broadway
Seattle WA 98122

SWEDISH MEDICAL CENTER

Financial Questionnaire

[GUARANTOR NAME AND ADDRESS]

DATE: _____

PATIENT NAME: _____

SERVICE DATE(S): _____

ACCOUNT NUMBER(S): _____

BALANCE DUE: $ _____

Family Size				
Total Family Size: _____	Name	Relationship	Age (DOB)	Employed Yes/No
Guarantor / Patient				
Spouse / Registered Domestic Partner				
Child				
Child				
Child				
Child				
Other Family Member				
Non-Citizens				
United States Sponsor				

Income (Monthly)				
	Person 1	Person 2	Person 3/ Sponsor	Grand Total
Gross Wages/Salary Employer Name/Phone# _____ _____ Start Date: Termination Date:	$ Employer Name/Phone# _____ _____ Start Date: Termination Date	$ Employer Name/Phone# _____ _____ Start Date: Termination Date	$ Employer Name/Phone# _____ _____ Start Date: Termination Date	$
Unemployment	$	$	$	$
Welfare Assistance (Cash)	$	$	$	$
Social Security	$	$	$	$
Retirement Benefits	$	$	$	$
VA Benefits	$	$	$	$
Workers Compensation	$	$	$	$
Income Producing Property (Rent)	$	$	$	$

Income (Monthly) continued				
	Person 1	**Person 2**	**Person 3/ Sponsor**	**Grand Total**
Other (Child Support)	$	$	$	$
Other	$	$	$	$
Other	$	$	$	$
Combined Total	**$**	**$**	**$**	**$**

Checking/Savings Accounts, Investments, and Insurance			
Does your household have a checking account? **Does your household have a savings account?**	☐ Yes ☐ Yes	☐ No ☐ No	Balance: $_____ Balance: $_____
Does your household have any Investments, IRA, CD's, etc.? **Are you drawing monthly income from Investments?**	☐ Yes ☐ Yes	☐ No ☐ No	Balance: $_____ Amount per Month: $_____
Have you applied for Medicaid in the past 90 days? **If yes, what was the determination:** **Provide copy of award letter.**	☐ Yes ☐ Approved	☐ No ☐ Denied	Date: _____
Do you have Medical Insurance? **Insurance:** **Policy#** **Group#** **Phone#** **Address:**	☐ Yes	☐ No	

List any other properties you own other than your primary residence.	**Type of Property (house, condo, etc)**	**Tax Assessed Value**	**Outstanding Mortgage**

I understand that the information provided by me is subject to verification by the hospital. I understand that any false information provided by me will result in a denial of any hospital financial assistance. Financial assistance is available only after all other forms of reimbursement (health insurance, Medicaid, or third party insurance) have been exhausted.

Signature: _____ Date: _____