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Charity Care/Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as charity care) at Swedish.

Federal and state law requires all hospitals to provide financial assistance to people and families who meet certain income requirements. You may qualify for free care or discounted care (you will be considered for both through this common application) based on your family size and income, even if you have health insurance. please go to the hospital website at https://www.swedish.org/patient-financial-visitor-info/billing/financial-assistance.

What does financial assistance cover? The medical financial assistance covers medically necessary care provided by one of our hospitals or clinics within our family of organizations 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: Our financial assistance policies, information about the programs, and the application materials are available on our website or via phone. You may obtain help for any reason, including disability and language assistance. Translated written documents available upon request.

Here's how to contact us:https://www.swedish.org/patient-financial-visitor-info/billing/financial-assistance.

Customer Service Representatives at: 206-320-5300 or +(1) 877-406-0438

Monday-Friday 8:30 am to 4:00 pm

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). If you live in California, household or family is determined in this way, *If the patient is 18 and older*, family includes, spouse, domestic partner, and any dependent children under 21 years old, or any age if disabled, whether living at home or not. *If the patient is under 18* or for a dependent child 18 to 20 years of age**,** family includes parents, relative caretakers, and parent's or relatives' caretakers', other dependents under 21 years of age, or any age if disabled.

- ❑ **Provide us information about your family's gross monthly income (income before taxes and deductions) to include pay stubs or tax returns, or other income information (e.g. W-2 forms, social security award letters) and statements for income drawn from assets.**[1] (see financial assistance application Income Section for more examples)
- ❑ **Attach additional information if needed**
- ❑ **Sign and date the financial assistance 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, your Social Security number may be used to identify you or 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**: Swedish Medical Center c/o Providence Regional Business Office, P.O. Box 31001-3422, Pasadena, CA 91110-3422 UNITED STATES OF AMERICA. Be sure to keep a copy for yourself.507846221.4

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To submit your completed application in person: Take to your nearest Hospital Financial Counselor's Office. We will notify you of the final determination of eligibility and appeal rights, if applicable, between 14 and 30 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.

[1] *Except as may be prohibited by state law, Swedish will collect and consider information related to assets as required by the Centers for Medicare and Medicaid Services (CMS) for Medicare cost reporting. This applies specifically to Medicare beneficiaries who do not also have Medicaid insurance. For all others, asset information is optional.*

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We want to help. Please submit your application promptly. You may continue to receive billing statements until we receive your completed application and required documentation unless prohibited by your state's charity care laws.

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Charity Care/Financial Assistance Application Form – 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** Is the patient Blind? □ **Yes** □ **No** Is the patient Disabled? □ **Yes** □ **No**
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 14-30 days after we receive your completed application and documentation, we will notify you of our determination.

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 Country 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** _____

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FAMILY INFORMATION					
List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together. **FAMILY SIZE** ——— *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
					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)- Income drawn from assets for example-stocks, bonds, IRAs, mutual funds, rental income, etc.

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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. <u>All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.</u>

<u>Examples of proof of income include:</u>

- A "W-2" withholding statement; or
- Current pay stubs (*3 months*); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Statements of income drawn from assets (stocks, bonds, IRAs, mutual funds, etc); or
- 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 Essential Living Expenses:

Rent/mortgage $_____ Medical expenses $_____

Medical Insurance Premiums $_____ Utilities $_____

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

ASSET INFORMATION AND DOCUMENTATION

Current checking account balance (See below to see if you need to provide a bank statement*)
$_____

General savings account balance
$_____

Does your family have these other assets? **Please check all that apply**

□No Assets

□ Stocks □ Bonds □ 401K □ Health Savings Account(s)

For Medicare beneficiaries without Medicaid insurance, Swedish may ask for bank statements or similar source documentation.

*This information is required only from Medicare beneficiaries who do not also have Medicaid insurance. For all others, this information is optional. This information may only be used in accordance with our policy and the State regulations in which you received care and is collected and considered as required by the Centers for Medicare and Medicaid Services (CMS) for Medicare cost reporting.

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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 Swedish 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