SWEDISH PHYSICIAN DIVISION

Dear Patient,

To be considered for Financial Assistance, you must provide the following:

1. The completed and signed Financial Questionnaire.

2. A copy of you and your spouse's most recent bank statement showing balance and activity for at least 60 days.

3. A copy of your previous year's IRS Tax Return.

4. Copies of you and your spouse's two most recent pay stubs to validate household income. (If you are self-employed, provide copies of three months Profit and Loss Statement).

5. Supporting documentation of all forms of income. For example: Public assistance award/ denial letters, alimony court orders, etc.

6. Verification of investment value(s). For example: Stocks, bonds, mutual funds, IRA, CD, 401K, trust funds, etc.

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 as well. Also, please verify that you have no source of income and how long it has been since you have 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 related to Swedish Medical Group. It will not apply to the bills for other medical groups, hospitals, or physician 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. If you have been approved for previous terms of Financial Assistance, you must apply for healthcare benefits through DSHS and submit a copy of the approval/ denial letter to our office along with this application before being approved for additional Financial Assistance.

If you have any questions, please contact our Customer Service Center at

(206) 320-4476 or (888) 294-9333. Our business hours are Monday – Friday from 8:00am to 5:00pm. Applications can be mailed to the address above, or faxed to our office at (206) 568-7043.

Sincerely,

Financial Services

SWEDISH PHYSICIAN DIVISION

Financial Questionnaire

1. Patient's Information

First Middle Last Date of Birth Social Security Number

Clinic Name Account Number Balance

Mailing Address City State Zip

Home Phone Cell Phone Work Phone

☐ Single ☐ Married ☐ Divorced ☐ Civil Union ☐ Separated

2. Guarantor/ Responsible Party's Information

First Middle Last Relationship to Patient

Home Phone Cell Phone Work Phone

Checking/ Savings Accounts, Investments, and Insurance

Does your household have a checking account? ☐ Yes ☐ No Balance $_____
Does your household have a savings account? ☐ Yes ☐ No Balance $_____
Does your household have any investments?
(401K's, IRA's, etc…) ☐ Yes ☐ No Balance $_____
Did you file taxes for the previous year? ☐ Yes ☐ No
Do you have Medical Insurance? ☐ Yes ☐ No
Insurance Company _____
Policy #_____
Group #_____
Phone # _____
Address _____
Have you applied for DSHS/ Medicaid? ☐ Yes ☐ No When? _____
Were you approved? ☐ Yes ☐ No
*Please provide a copy of your award/ denial letter.
Is this application for past or future services? ☐ Past ☐ Future

For Clinic Use Only

☐ Approved at _____% Effective from _____ to _____
☐ Not Approved. Reason: _____
Financial Services Representative _____ Date: _____

Swedish Physician Division • PO Box 84026 • Seattle, WA 98124-8426
Phone: (206) 320-4476 or (888) 294-9333 • Fax: (206) 568-7043

SWEDISH PHYSICIAN DIVISION

Family Size				
Total Family Size _____	Name	Relationship	Age	Employed? (yes/no)
Patient/ Guarantor				
Spouse				
Child				
Child				
Child				
Other Family Member				

Monthly Income				
	Patient/ Guarantor	Spouse	Other Family Member	Grand Total
Gross Wages/ Salary	$	$	$	$
Employer				
Start Date				
End Date				
Unemployment	$	$	$	$
Social Security	$	$	$	$
Retirement	$	$	$	$
Worker's Comp	$	$	$	$
Child Support	$	$	$	$
DSHS (cash)	$	$	$	$
Food Stamps	$	$	$	$
Property	$	$	$	$
Other Income	$	$	$	$
Combined Total	$	$	$	$

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

Patient/ Guarantor Signature Date Spouse Signature Date

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SWEDISH PHYSICIAN DIVISION

REQUIRED FORM

Swedish Physician Division
Financial Services
Phone (206) 320-5979
Fax (206)320-7043

Employment and Unemployment Verification Form

FOR STAFF USE ONLY:

Employment Security Department
Attn: Records Disclosure
Fax Number: (360) 586-2133
Phone Number: (360) 586-2132

Application's Name*: _____

Social Security Number*: _____

I authorize Swedish Physician Division to request any records or information about me relating to unemployment benefits and employment history from the Employment Security Department.

Applicant's Signature**: _____Date:_____

Spouse/ Significant Other's Name*: _____

Spouse's Social Security Number*: _____

I authorize Swedish Physician Division to request any records or information about me relating to unemployment benefits and employment history from the Employment Security Department.

Spouse's Signature**: _____Date:_____

*Information must be provided and printed clearly
**Signature Required

For the above applicant, our office is requesting the following:

Unemployment information and payment history for the last year
Employment history for the last 4 completed quarters

Comments:

This form is for Swedish Physician Division verification purposes for Financial Assistance.