UW Medicine
VALLEY
MEDICAL CENTER

PO Box 59148
Renton, WA. 98058-9900
Phone (425) 251-5178
Fax (206) 575-2573

Valley Medical Center's Financial Assistance Application

Valley Medical Center has financial programs, which may assist you with your bill. To determine if you qualify for financial assistance, please fill out attached form and provide a copy of the document(s) listed below in the section that applies.

EMPLOYED - *(please send proof of any/all of the income items below that pertain to you and/or your spouse)*

- Past three months check stubs showing year-to-date income for **both husband and wife.** If paid more than once a month, please provide complete month's worth of paycheck stubs. If you do not have stubs, you can request stubs from your employer or have employer submit a letter stating when hired, rate of pay, and hours worked per week
- Child support and/or alimony documentation
- Previous year tax return – can be requested from the IRS if you do not have a copy.
- Previous 3 months bank statements (all Checking and Savings accounts)

SELF-EMPLOYED - *(please send proof of any/all of the income items below that pertain to you and/or your spouse)*

- Previous year's tax return for the self-employed individual
- Year to date profit & loss (Schedule C)
- Copies of check stubs if you pay yourself
- 3 months of current Bank Statement (Checking and Savings)
- Proof of income of spouse if applicable

UNEMPLOYED – *(please send proof of any/all of the income items below that pertain to you and/or your spouse)*

- Unemployment check stubs or determination letter
- Worker's Compensation award letter
- Social Security income verification (Bank statement, award letter, or copy of the check)
- Strike Benefits
- Disability Benefits
- Pension Benefits
- Previous three months bank statements (Checking and Savings)
- Child support and/or alimony documentation
- If you are unemployed or have no other income, a letter written by friends/relatives stating type of support provided
- Previous year's tax return

Please return the requested documentation within 14 business days. If you have any questions about the requested documentation, please contact the Hospital Patient Financial Services Department at (425) 251-5178 and choose option 4 during the hours of 8:00 - 5:00 Monday through Friday.

Thank you for choosing Valley Medical Center for your healthcare needs.

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Financial Assistance Application

DATE:
PATIENT NAME:
ACCOUNT NUMBER(S):
ADDRESS:

Please provide the following information completely and accurately in order to ensure timely processing of your application. All information provided is subject to verification.

Total Family Size:	Name		Date of Birth
Guarantor / Patient			
Spouse			
Child			
Child			
Child			
Child			
Other Family Member			
Sponsor (If Applicable)			
Income Verification	**Self**	**Spouse**	**Sponsor** *US citizen financially responsible for patient
Employment Verification	Employer Name Monthly Gross Income $________________ Start Date: Term Date:	Employer Name Monthly Gross Income $________________ Start Date: Term Date:	Employer Name Monthly Gross Income $________________ Start Date: Term Date:
Unemployment	$	$	$
DSHS Assistance (Income)	$	$	$
Social Security	$	$	$
Retirement Benefits	$	$	$
VA Benefits	$	$	$
Workers Compensation	$	$	$

Income Verification	Self	Spouse	Sponsor
Income Producing Property (Rental/s)	$	$	$
Other (Child Support)	$	$	$
Other	$	$	$
Combined Total Monthly Income:	**$**	**$**	**$**
Does your household have a checking account?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does your household have a savings account?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does your household have any Investments, IRA, CD's, etc.?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Are you drawing monthly income from Investments?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you applied for Medicaid in the past 90 days? **If yes, what was the determination:** **Please provide copy of award/denial letter.**		☐ Yes ☐ Approved	☐ No ☐ Denied
Do you have Medical Insurance? **Insurance: Phone#** **Policy# Group#** **Address:**		☐ Yes	☐ No
List any other properties you own other than your primary residence.		**Type of Property (house, condo, etc)**	**Tax Assessed Value**

I certify that the information provided is an accurate and true representation of my financial information and is subject to review by Washington State and/or Federal enforcement agencies and others as required. I also certify that there is no additional insurance coverage for this patient other than what was listed at the time of registration. I understand that In accordance with Washington Health Care False Claims Act Section 40.80.030, providing false information to defraud a hospital for the purpose of obtaining goods or services is a C class felony, punishable under 9A.20.RCW and providing false information will result in a denial of the application for any type of assistance through Valley Medical Center.

I also agree to apply for any state assistance, if it is determined that I would potentially qualify for any programs. My failure to apply for such assistance or failure to take actions reasonably necessary for eligibility determination as requested by Valley Medical Center will also result in a denial of this application. I am aware that Valley Medical Center may check my credit history through the credit bureau, if deemed appropriate.

Signature: ____Date: ______________________