Dear Patient and Family:

Medical bills may be hard to pay. First Hill Surgery Center works with patients to see if they qualify for interest free payment plan options or financial assistance discounts. If financial assistance is granted, some or all balances may be reduced.

To be considered for financial assistance please provide the following documents:

1. The completed and signed Request for Financial Assistance.

2. Verification of family/household income (below are some examples of items that can be sent to show your income).

a. Two most recent paystubs

b. Profit and Loss statement from previous quarter

c. Public assistance approval or denial letter

d. Social Security benefit letter

e. Most recent year's tax return

3. If you are claiming no income or you feel there are other circumstances that might affect your eligibility, please 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 include how long it has been since you have not had a source of income.

4. For families who are over 100% of the federal poverty level, documentation may be needed to validate any available assets. The most recent federal poverty levels can be seen on our website http://www.firsthillsurgerycenter.com/ or by contacting Financial Counselors.

Return your application and supporting documents as soon as possible so we may help you resolve your balance. FHSC has Financial Counselors who can provide in person help if needed.

Please note that if financial assistance is given it will only cover eligible medical bills from FHSC facility. It will not apply to bills for other medical groups, hospitals, or physicians' groups. Please contact other medical groups directly about their financial assistance options.

When you apply for financial assistance you are giving consent for us to look into your financial obligations or references as needed.

Application packets can be returned in person or by mail to the department and address below.

Patient Financial Services
Attn: Financial Counselors
1101 Madison St., Suite 200
Seattle WA 98104

First Hill SURGERY CENTER

Request for Financial Assistance

I. Patient Information

PATIENT'S NAME LAST	FIRST	MI	TELEPHONE HOME
ADDRESS STREET	CITY STATE ZIP		TELEPHONE WORK
DATE OF BIRTH	PRIMARY CARE PHYSICIAN (PCP)		U.S. CITIZEN ❑ YES ❑ NO **If no, we may be able to help you apply for a special Medicaid Program in addition to our Financial Assistance.**

II. Guarantor Information (Person responsible for the bill)

NAME OF PERSON RESPONSIBLE FOR PAYING THE BILL		RELATIONSHIP TO PATIENT
ADDRESS STREET	CITY STATE ZIP	Date of Birth
TELEPHONE NUMBER HOME	WORK	

❑ Please check this box if you have not received services and are applying to pre-qualify.

Are you being referred by a physician or surgeon? ❑ YES ❑ NO

If yes, please provide name and phone of number of physician ______________________________

III. Household Information – Please indicate ALL people living in your household, including applicant use additional paper if needed

Please list anyone living in your household (including yourself). Income includes (pre-tax) wages, child support income, alimony income, income from rental property, unemployment compensation, social security benefits, public/government assistance, rent or living expenses exchanged for services provided, fund drawn from retirement accounts, stocks, bonds, etc.

HOUSEHOLD MEMBER NAME	AGE	RELATIONSHIP TO PATIENT	SOURCE OF INCOME OR EMPLOYER NAME	MONTHLY GROSS INCOME PRIOR TO DATE OF SERVICE	INSURED? (circle yes or no) If yes, list insurance (i.e. Blue Cross, UHC, etc.)
1.					Yes or No
2.					Yes or No
3.					Yes or No
4.					Yes or No
5.					Yes or No
6.					Yes or No
7.					Yes or No
8.					Yes or No

Continued on the other side.

IV. Expenses and Assets

This information may be used to assist you with a longer term payment plan or a discount exception if you are not qualified for our standard financial assistance discount based on your family size and income. Additional information or verification documents may be required to process your application. If so, we will contact you.

Amount paid for rent or mortgage ___________________________

Cost of utilities ____

Car payment ____

Monthly child care ____

Health insurance premium __________________________________

Monthly cost of mediations or medical supplies_________________

Checking account balance __________________________________

Savings account balance ___________________________________

Are you a full time student? ❑ Yes ❑ No

Are you being supported by a parent or other person? ❑ Yes ❑ No

If yes, please provide income information of the person supporting you.

If you need to write a letter explaining your individual situation please attach it to this form.

VI. Authorization

I hereby certify the information contained in the above financial questionnaire is correct and complete to the best of my knowledge. I authorize First Hill Surgery Center to verify any or all information given.

X ____ ______________________

RESPONSIBLE PERSON'S SIGNATURE DATE