Northwest Ambulance
PO Box 3510 – Silverdale, WA 98383
Phone: 800-238-9398 Fax: 360-697-1659

Charity / Indigent Care Application & Check List

The following documentation must be provided in order to process your Charity / Indigent Care Application:

- Proof of household income via four most recent pay stubs of all employed in the household. **Please provide a copy of your most recent federal income tax return.** Proof of workers compensation, sick leave, disability compensation, welfare, or social security retirement (SSI not included in income determination), if applicable. If child living with you is under 21 and employed, proof of income may be in the form of a pay stub or certified letter.
- If you are not married but there are children in common, you must provide entire household income. Any child support or alimony received must also be included.
- If you are still legally married but separated, you must provide legal documentation of separation or spouse's income.
- If you lost your job within the last three months, you are required to provide a separation letter from you past employer. Additionally, you must provide a letter from your local unemployment office specifying whether or not you are receiving unemployment benefits. If you have no income at this time, provide a signed and notarized letter from the person who provides room and board for you and your family, if applicable.
- If you have listed any children on your application other than biological or stepchildren, you must provide legal documentation to this effect.
- Proof of home address: Valid Driver's License, Identification Card, current utility bill, lease or rent receipts showing evidence of residence, county property tax assessment, state food stamp letter.

You are required to return all information within the next 15 days. This application does not guarantee that your account will not follow collection process. Your accounts will not be placed on hold pending charity consideration.

You will receive an approval or denial letter upon completion of application review.

Sincerely,

Charity Care Assistance Program

Send the completed application and all requested documentation to:

Northwest
Ambulance
c o Systems Design
PO Box 3510
Silverdale, WA 98383-3510

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Charity / Indigent Care Application & Check List

Date_____

Last Name _____ First Name_____ MI___

Account Number _____ Date of Birth _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Do you have any form of health Insurance? ☐ Yes ☐ No (if yes with whom)_____

Insurance Policy Number: _____ Group Number:_____

Do you have a Washington State Medicaid Card? ☐ Yes ☐ No

If yes – please provide a copy of your card – Card Number: _____

Are you on Medicare? ☐ Yes ☐ No Do you have a Supplement to your Medicare? ☐ Yes ☐ No

If yes – please provide a copy of your card – Card Number_____

Supplemental Insurance: _____ Policy / Group Number: _____

Supplemental Insurance: _____ Policy / Group Number:_____

Are your children on Health Insurance: ☐ Yes ☐ No

If yes please provide a copy of your card – Card Number: _____

Address: _____
(Number) (Street) (City) (State) (Zip)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Parent or Guardian if patient is under 21:_____

Patient (or Guardian) Employer: _____

Employer Address: _____

Are you Self Employed? ☐ Yes ☐ No - Type of Work: _____

Spouse's Employer: _____

Employer Address:_____

Is your Spouse Self Employed? ☐ Yes ☐ No – Type of Work: _____

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DEBT/EXPENSES	UNPAID BALANCE	MONTHLY AMOUNT	ASSETS (LIST)	VALUE	AMOUNT OWED
			CASH	$	N/A
MORTGAGE/RENT	$	$		$	$
FOOD	$	$		$	$
UTILITIES	$	$		$	$
CLOTHING	$	$		$	$
TRAVEL	$	$		$	$
MEDICAL	$	$		$	$
TAXES	$	$		$	$
INSURANCE	$	$		$	$
LOAN (ATTACH DETAILS)	$	$		$	$
BUSINESS DEBTS AND EXPENSES	$	$		$	$
MISCELLANEOUS EXPENSES	$	$		$	$
OTHER LIABILTIES (I.E. PRESENT LAWSUITS, GARNISHMENTS, REPOSSESSION, FORECLOSURES)	$	$	OTHER	$	$
TOTAL	$	$	**TOTAL**	$	$

RESOURCES/INCOME		HOUSEHOLD MEMBERS		
SOURCE	MONTHLY AMOUNT	NAME	BIRTH DATE	RELATIONSHIP
EMPLOYEE (GROSS)	$			
SELF –EMPLOYMENT	$			
SOCIAL SECURITY	$			
RETIREMENT	$			
RENTAL INCOME	$			
INTEREST	$			
DIVIDENDS	$			
UNEMPLOYMENT	$			
ALIMONY	$			
CHILD SUPPORT	$			
OTHER	$			
TOTAL	$			

- I certify that this form has been examined by me and that the information given is true and correct to the best of my knowledge.
- I understand that I must apply for any other benefits which might pay these accounts before charity can be approved (e.g. Medicaid, Medicare, etc.).
- I understand that giving false information in regards to this application and approval for charity care that the approval may be reversed and legal action may be pursued. Further, I understand that NW Ambulance may obtain any credit history of mine or my spouse.

Signature of Patient or Guardian:_____Date_____

Relationship to Patient:_____

Signature of Spouse:_____Date_____

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