FRANKLIN CO PHD 1
PO Box 246 | Mesa, WA 99343-0246
Tel: (509) 269-4900 | Fax: (509) 269-4977

Individual Written Notice of Financial Assistance

It is the policy of Franklin Co PHD 1 that no person will be denied needed emergency medical care because of an inability to pay for such services.

Our practice abides by the contractual and legal obligations of health benefit plans to collect charges, co-pays, co-insurance and deductible amounts owed by patients. Recognizing that circumstances may arise where an individual is unable to pay in full at the time of service, we have adopted a policy of screening requests for forgiveness of debt based on individual circumstances in relation to the Federal Poverty Guidelines. To do this, we must ask for certain financial information. All information will be held confidential according to our privacy policy.

If you think you may be eligible for Financial Assistance, please complete and sign the application **on the reverse side of this page** and provide as many of the following supporting documents as you are able:

1. Copy of pay stubs for the last 2 months from your last place of employment.
2. Verification of your current employment/unemployment status.
3. A copy of your W-2 forms for the previous year.

Please mail your Financial Application and all supporting documents to:

Franklin Co PHD 1
c/o Systems Design
PO Box 3510
Silverdale, WA 98383-3510

You will be notified of any reduction in your bill once the Franklin Co PHD 1 has reviewed your application.

THIS SECTION TO BE COMPLETED BY BILLING AGENCY	
Patient Name:	Incident Date:
Authorized by Franklin Co PHD 1 Personnel:	
1)	2)
Comments	

FINANCIAL ASSISTANCE APPLICATION

Franklin Co PHD 1

c/o Systems Design West Billing Services
P.O. Box 3510, Silverdale, WA 98383

Phone: (360) 394-7010 or (800) 238-9398
Fax: (360) 394-7097

RESPONSIBLE PARTY		
Name:	Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced	Social Security Number:
Street Address:	City, State, Zip Code	How long at this address?
Employer's Name (if employed, how long?):	Employer Address:	Business Phone No.:
Position / Title:	Monthly Income—Gross:	Monthly Income—Net:

SPOUSE/OTHER RESPONSIBLE PARTY		
Name:		Social Security Number:
Employer's Name (if employed, how long?):	Employer Address:	Business Phone No.:
Position / Title:	Monthly Income—Gross:	Monthly Income—Net:

OTHER QUALIFYING DEPENDENTS	
Number of Other Qualifying Dependants:	Name(s) & Age(s):

MISCELLANEOUS INCOME PER MONTH		
INCOME SOURCE**	**AMOUNT *(Per Month)***	**COMMENTS**
Public Assistance *(Per Month)*	$	
Social Security Income *(Per Month)*	$	
Unemployment Compensation *(Per Month)*	$	
Worker's Compensation *(Per Month)*	$	
Alimony / Child Support	$	
Pension, Retirement Income	$	
Dividends, Interest	$	
Savings/Checking	$	
Other Income *(Please Explain)*	$	

OTHER PERTINENT INFORMATION

List any other information that you feel may influence a decision regarding your account:

****Note** the source of your income listed and what type of documentation you are providing. Examples of documentation you may use to support your income amounts recorded above would be: paycheck stubs, W-2s, letter from employer, award letter from DSHS, VA or Social Security benefit determination letter, worker's compensation award notice, verification of child support through copy of decree, or actual check from supporting parent.

In completing this financial statement, I hereby affirm that the above statements are correct and complete, and I give my consent to further verification by Franklin Co PHD 1 or its agents.

Signature	Date