JEFFERSON COUNTY FPD 2
(DBA QUILCENE FIRE RESCUE)
c/o Systems Design
PO Box 3510, Silverdale, WA 98383
(800) 238-9398

Individual Written Notice of Financial Assistance

It is the policy of the Quilcene Fire Rescue that no person will be denied needed emergency medical care because of an inability to pay for such services.

Quilcene Fire Rescue will provide needed emergency services without charge or at a reduced charge and without discrimination to those persons with no or inadequate means to pay for needed care.

To be eligible to receive needed ambulance services without charge or at a reduced charge, you or your family's annual income must be at or below certain levels established by national poverty guidelines for this area.

If you think you may be eligible for Financial Assistance, please complete and sign the application **on the reverse side of this page,** attach documentation for any listed income or grant of "hospital charity," and send to:

Jefferson County FPD 2
c/o Systems Design
PO Box 3510
Silverdale, WA 98383-3510

You will be notified of any reduction in your bill once the Quilcene Fire Rescue has reviewed your application.

THIS SECTION TO BE COMPLETED BY BILLING AGENCY	
Patient Name:	Incident Date:
Authorized by Quilcene Fire Rescue Personnel:	
1)	2)
Comments	

FINANCIAL ASSISTANCE APPLICATION

Quilcene Fire Rescue

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

Phone: (360) 394-7010 or (800) 238-9398
Fax: (360) 697-1659

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 RESPOSIBLE 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, income tax return, 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 Quilcene Fire Rescue or its agents.

Signature	Date