Request for Financial Assistance

Dear Patient and Family:

In keeping with its mission and core values, Providence Health & Services is committed to providing health care for people regardless of their ability to pay.

Providence Financial Assistance Medical bills may be difficult to pay. Patients who do not have health insurance and who are unable to pay for all or part of their health care services, may apply for financial assistance by completing and returning this form.

Options Available PH&S will work with patients to see if they qualify for Medicaid, Medicare, private insurance, interest free payment plan options, or financial assistance. If financial assistance is granted, some or all charges may be lowered.

Application Process To apply for financial assistance, complete and return this form to Providence Health & Services, Attn: Regional Financial Counselor Team, PO Box 196604, Anchorage, AK 99519-6604, or fax to (907) 212-6516.

The following information must be included with the application: **Failure to supply this info will lead to a delay in processing your application.**

1. Most recent Federal Tax Returns – Form 1040 and if self employed add Schedule C documentation.
2. Most recent two months bank statements, all pages.
3. Copies of the most recent income information for each person in the household including pay stubs, Social Security, unemployment, retirement, pensions, etc. For S/E provide 90-day P+L statement.
4. If the household is receiving financial support from family or friends, provide a letter detailing the support from the assisting party. PH&S may also request proof of income depending on the level and duration of support. If there is no income to report, please provide letter of explanation.

Questions?

Please call the Providence Health & Services Financial Counselors (907) 212-6049, M-F, 8 a.m. - 5 p.m.

This application must be fully completed, signed and include the supporting documentation to be considered for assistance. Please return within 14 days of receipt.

By submitting application for assistance, patients give Providence Health & Services consent to make necessary inquiries to confirm financial obligations or references.

Sincerely,
Providence Health & Services

Providence Health & Services strives to provide excellent service for your health care needs.

PROVIDENCE IMAGING CENTER

Request for Financial Assistance

I. Patient Information

PATIENT'S NAME LAST	FIRST	MI	SOCIAL SECURITY NUMBER
ADDRESS STREET	CITY STATE ZIP		TELEPHONE HOME WORK
DATE OF BIRTH	PRIMARY CARE PHYSICIAN (PCP)		U.S. CITIZEN ❑ YES ❑ NO

II. Guarantor Information

NAME OF PERSON RESPONSIBLE FOR PAYING THE BILL		RELATIONSHIP
ADDRESS STREET CITY STATE ZIP		SOCIAL SECURITY NUMBER
TELEPHONE NUMBER HOME WORK	U.S. CITIZEN ❑ YES ❑ NO	DATE OF BIRTH

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

Have you been approved for Financial Assistance by another Health Care organization? ❑ YES ❑ NO

If yes, please provide name of organization ______________________________

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, rental income, unemployment compensation, social security benefits, public/government assistance, rent or living expenses exchanged for services provided, etc.

HOUSEHOLD MEMBERS	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, PHP, 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
9.					Yes or No

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IV. Expenses and Assets

Rent ______________________

Mortgage payment ______________ Send proof

Mortgage balance ______________ Send proof

Cost of utilities ______________________

Checking account balance ______________________

Savings account balance ______________________

Car payment ______________________

Year and make of vehicle ______________________

Recreational vehicles ______________________

Health insurance premiums ______________________

Stocks, bonds, retirement accounts, etc. ______________________

Monthly child care ______________________

Real estate other than primary home ______________________

Other assets ______________________

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Are you a full time student? __________ Please send student loan report.

Do you receive any form of public assistance (food stamps, HUD housing, etc.) __________ If yes, please send proof.

Monthly costs of medications or medical supplies ______________________

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

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

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

V. Required Information – Must be included with this application

Please check that you have included the following:

- ❑ Copy of previous year's tax returns
- ❑ Copy of last 3 months bank statements
- ❑ Income verification showing earnings or pay stubs for all income year to date

❑ If you are self employed, please include a copy of the last 12 month's P & L statements and last year's tax return.

Additional information may be required in order to process your application. If so, we will contact you.

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 Providence Health & Services to verify any or all information given and understand that a credit report may be run as part of this verification process.

X ______________________________ ______________________

RESPONSIBLE PERSON'S SIGNATURE DATE