**Northwest Gastroenterology**
**Northwest Endoscopy Center** **Financial Assistance Application Form – CONFIDENTIAL**

Please fill out all information completely. If it does not apply, write "NA". Attach additional pages if needed.

| SCREENING INFORMATION |
|---|
| Do you need an interpreter? ☐ Yes ☐ No *If Yes, list preferred language:* |
| Has the patient applied for Medicaid? ☐ Yes ☐ No *Application may be required before being considered for financial assistance* |
| Does the patient receive state public services such as TANF, Basic Food, or WIC? ☐ Yes ☐ No |
| Has the patient been approved for Bridge Assistance from PeaceHealth? ☐ Yes ☐ No |
| Is the patient currently homeless? ☐ Yes ☐ No |
| Is the patient's medical care need related to a car accident or work injury? ☐ Yes ☐ No |

**PLEASE NOTE**

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

**PATIENT AND APPLICANT INFORMATION**

| Patient First Name | Patient Middle Name | Patient Last Name |
|---|---|---|
| ☐ Male ☐ Female<br>☐ Other (may specify: _____) | Medical Record Number (If known) | Patient Birth Date |

| Person Responsible for Paying bill (Guarantor) | Relationship to Patient | Guarantor Birth Date |
|---|---|---|
| | | |

| Mailing Address | Main contact Numbers |
|---|---|
| _____<br>_____<br>City State Zip Code | ( ) _____<br>( ) _____<br>Email Address: _____ |

Employment Status of Person Responsible for Paying Bill

☐ Employed (date of hire: _____) ☐ Unemployed since date: _____

☐ Self Employed ☐ Student ☐ Disabled ☐ Retired ☐ Other: _____

**FAMILY INFORMATION**

List family members in your household, including yourself. "family" includes people related by birth, marriage, or adoption who live together and are claimed as dependents on your most recently filed federal income tax return.

**FAMILY SIZE: _____ SUBMIT YOUR LAST TAX RETURN WITH THIS APPLICATION**

**NOTE: All adult family members' income must be disclosed**. Sources of income may include, for example: -wages -unemployment -self-employment -Workers compensation -Disability -SSI -Child/spousal support -Work study programs (students) -Pension -Retirement account distributions -Other

| Name | Date of Birth | Relationship to Patient | Employer(s) name or source of income | Total gross monthly income (before taxes) | Also applying for financial assistance? |
|---|---|---|---|---|---|
| | | | | | Yes / No |
| | | | | | Yes / No |

| Name | Date of Birth | Relationship to Patient | Employer(s) name or source of income | Total gross monthly income (before taxes) | Also applying for financial assistance? |
|---|---|---|---|---|---|
| | | | | | Yes / No |
| | | | | | Yes / No |
| | | | | | Yes / No |
| | | | | | Yes / No |
| | | | | | Yes / No |
| *Attach additional page if needed* | | | | | |

## INCOME INFORMATION

We use this information to get a more complete picture of your financial situation. *(Please attach another page to list out other debts, if needed.)*

Monthly Household Expenses:

Rent/Mortgage $_____ Medical Expenses $ _____

Insurance Premiums $_____ Utilities $_____

Other Debt/Expenses $_____ describe: _____

## ASSET INFORMATION

Current Checking Account Balance $_____

Current Savings Account Balance $ _____

Does your family have these other assets?

☐ Stocks ☐ Bonds ☐ 401K ☐ Health savings Account

☐ Property (excluding primary residence) ☐ Own a business

## ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, seasonal or temporary income, or personal loss.

## PATIENT AGREEMENT

I understand that NWG/NWEC may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.

_____ _____

Signature of Person Applying Date

## CONTACT INFORMATION

| | | |
|---|---|---|
| Attn: Billing<br>Northwest Gastroenterology<br>3111 Woburn St, Ste 201<br>Bellingham WA 98226 | Attn: Billing<br>Northwest Endoscopy Center<br>3111 Woburn St, Ste 101<br>Bellingham WA 98226 | Contact Billing:<br>Patient Portal: nwgastro.com<br>Phone: (360) 734-1420 option 5<br>Fax: (360) 733-1659 |