Bellingham Fire Department
1800 Broadway | Bellingham, WA 98225-3133
Tel: (360) 778-8400 | Fax: (360) 778-8401

INDIVIDUAL WRITTEN NOTICE OF FINANCIAL ASSISTANCE

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

Bellingham Fire Department 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:

Bellingham Fire Department
c/o Billing Services
PO Box 35176
Seattle, WA 98124-5176

You will be notified of any reduction in your bill when the Fire Department has reviewed your application.

Patient's Name	Contact Phone
Date of Service	
Transported to:	

Responsible Party	
Name	
Relationship	
Current Employer	
Employed From	
Previous Employer	
Spouse Employer	
Employed From	
Previous Employer	

Income	Family Member 1	Family Member 2	Family Member 3	Family Member 4
Name				
Relationship				
Wages				
Self-Employment				
Public Assistance				
Social Security				
Unemployment				
Worker's Comp.				
Alimony				
Child Support				
Pension/Retirement				
Dividend Income				
Rental Prop. Income				
Other Income (detail)				
Total Income				

Please attach documentation of any listed income such as W-2s, pay stubs, tax returns, forms approving or denying eligibility from Medicaid and/or state-funded medical assistance, forms approving or denying unemployment compensation or written statements from employers or welfare agencies.

Was charity care granted by the receiving medical facility? **Yes** **No** ☐ ☐
Please attach documentation of charity-care decision by the receiving medical facility.

The above information is correct to the best of my knowledge. I authorize Bellingham Fire Department to verify for the purpose of financial assistance eligibility determination.

Signature (Patient or Responsible Party) Date

Current account balance	Adjustment (by City)	New Balance

Signature (Bellingham Fire Department) Date