KITTITAS VALLEY FIRE & RESCUE

Request for Financial Assistance

It is the policy of Kittitas Valley Fire & Rescue (KVFR) that no person will be denied needed emergency medical care because of an inability to pay for such services.

KVFR may reduce or waive charges for services without discrimination based on the responsible party's ability to pay.

To be eligible to receive needed ambulance services without charge or at a reduced charge, you or your family's 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 attached application and the following supporting documents.

Application:

☐ Completed application for financial assistance

Proof of Gross (pre-tax) income – For all household members:

☐ The *last 3 pay stubs* for all employed household members (i.e. Wages, Salaries, Tips, Commissions, etc.)

☐ Proof of pensions, retirement, unemployment or disability benefits.

☐ Child Support/alimony

☐ Social Security award letter. – *Your bank statement does not always show the gross amount.*

Taxes:

☐ Most recent year's "Complete" **Federal** tax return that you were claimed on. (If you do not have your tax return, you can visit www.irs.gov or call 317-685-7500 to order a "tax return transcript"). State taxes and W-2s are not acceptable.

- If you do not file taxes, or are a legally documented alien, please provide a copy of your social security card and/or proof of citizenship status.

Bank Statements:

☐ Last three months of complete bank statements for all accounts (including business accounts)

- For the bank statements, "Complete" means that if the statement says, "page 1 of 6," ALL 6 pages are needed, even if some of them are intentionally left blank. *Account Summaries or Transaction Histories are not acceptable.*

Residency (if claiming no income):

☐ Statement of support from person(s) providing room and board with their name, address and what is being provided.

☐ Current homeless shelter residency verification

Incomplete or inaccurate financial reporting will be cause to reject the financial assistance request.
Please fax your application and paperwork to 360.394.7097 or mail to: Kittitas Valley Fire & Rescue, c/o Systems Design, PO Box 3510, Silverdale, WA 98383-3510

APPLICATION FOR FINANCIAL ASSISTANCE

Please complete this application and return it along with **all supplemental documentation required within 15 days** to avoid possible denial of your application. The information you provide will be held in strict confidence and will not be used for any purpose other than to assess your need for financial assistance. We will not share this information with any person or organization outside of Kittitas Valley Fire & Rescue.

Please provide the following information completely and accurately. Information is subject to verification. Please attach a list of additional household members if there are more than five (5) members.		
Patient Name (First, MI, Last)	SSN	Total # of household members
Address	Date of Birth	Home/Cell Phone
City/State/ZIP		Work Phone
Guarantor Name	Account #	

Dependents may live outside of your primary household residence if they are claimed on your or your spouse's tax return.

List ALL household member names	Date of Birth	SSN	Relationship to Patient	Insurance
1		- -		Yes / No
2		- -		Yes / No
3		- -		Yes / No
4		- -		Yes / No
5		- -		Yes / No

Monthly Budget			
Gross Monthly Income (GMI)		**Transportation:**	
Source:	$	Gas & Oil	
Source:	$	Total	$ ______________
Source:	$	**Medical/Health:**	
Source:	$	Current Bills	$ ______________
Source:	$	Medications	$ ______________
Total	$ ______________	Total	$ ______________
Monthly Expenses		**Insurance:**	
Housing:		Auto Insurance	$
Mortgage/Rent	$	Health Insurance	$
Total	$ ______________	Homeowners/Renter Insurance	$
Utilities:	$	Life Insurance	$
Electricity/Gas/Water	$	Total	$ ______________
Internet/Cable	$	**Debts:**	
Phone/Mobile	$	Car Payment(s)	$
Trash	$	Child Care	$
Total	$______________	Credit Card(s)	$
Food:		Student Loans	$
Groceries	$	Other	$
Total	$ ______________	Total	$ ______________
		Total Expenses	$ ______________

I CERTIFY that the information I have provided is a true and accurate representation of my family size and household income. I understand that any misrepresentation of this information will result in denial of financial assistance. I authorize KVFR to access additional sources of information to verify my qualification for assistance.

Applicant/Patient Signature____ Date ______________________

Spouse Signature (if co-applicant) ________________________________ Date ______________________

Thank you for your application and for the opportunity you have given us to serve your health care needs.
Please return your completed application and all supporting documentation to: **Fax Number: 360.394.7097, or U.S. Mail Address: KVFR c/o Systems Design West Billing Services, PO Box 3510, Silverdale, WA 98383. Please call 800.238.9398** if you have any questions or need assistance with this application. **We will notify you of our decision in writing within 45 days of the receipt of your application.**