Northwest Ambulance
PO Box 3510 | Silverdale, WA 98383 Phone:
(888) 824-9225 | Fax: (360) 394-7094

Financial Hardship Request Form

Instructions to Patient: Please complete this form in its entirety and return it to:
Northwest Ambulance, PO Box 3510 Silverdale, WA 98383

Patient Name: _____
Patient ID: #_____
Address: _____
City/State/Zip: _____

Responsible Party (if different than patient): _____
Address: _____
City/State/Zip: _____

I am applying for a Hardship Determination in order that you will consider waiving my co-pay/co-insurance/deductible (or total charges if uninsured) for service and care provided to me.

I am supplying the following information so that you can make an accurate determination of my case. The monthly dollar amount provided is from all sources including Social Security benefits, pensions, annuities, dividends, current and former jobs (whether I worked as an employee or independent contractor), alimony, child support, interest, winnings, one-time payments, etc. Attached you will find verification of my income including employment/unemployment status, verification of the number of people in my household, and copies of my and all others living at my residence's federal tax returns or W-2 and 1099 forms for the previous 2 years, as well as other information I feel should be considered in determining my ability to pay. I understand that financial hardship determinations cannot be made until I have completed this entire form and submitted all the required documents to Northwest Ambulance.

Insurance Company: _____; Insurance Policy/ID Numbers: _____

Monthly Income	Self		Others Living at My Residence		
Wage/salary	$_____		$_____		
Social security	$_____		$_____		
Pension	$_____		$_____		
Interest income	$_____		$_____		
Other	$_____		$_____		
Totals	$_____	+	$_____	=	$_____

Total size of household: _____

Patient Signature: _____ Date: _____