Individual Written Notice of Financial Assistance

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

The Shoreline Fire Department will provide needed emergency service without charge or at a reduced cost without discrimination to those persons with documented inadequate or no means to pay for care.

To be eligible to receive needed ambulance transport services without charge or at a reduced cost, you or your family's gross annual income must be at or below levels established by national poverty guidelines for this area.

You may also qualify for financial assistance from the Shoreline Fire Department if you have been granted financial assistance by the medical facility to which you were transported.

If you think you may be eligible for Financial Assistance under this policy, please complete and sign the application below, attach the required income documentation or provide a grant of "hospital charity" and submit the completed application packet to:

Shoreline Fire Department
c/o Systems Design
P.O. Box 3510
Silverdale, WA 98383

You will be notified of the determination made in your request for financial assistance and any reduction in your charges once the Fire Department has reviewed your application.

Patient	
Name:	
Contact Phone:	
Date of Service:	
Hospital transported to:	
Responsible Party	
Name: (if different from patient)	
Relationship:	
Current Employer:	
Employed From:	
Previous Employer:	
Spouse Employer:	
Employer 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:				
Child Support:				
Pension/Retirement:				
Other Income:				
Total Income:				

Please attach documentation of any listed income such as W-2's, pay stubs, tax returns, or 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** ☐
If **Yes,** please attach documentation of the charity care decision by the receiving medical facility.

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

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Signature (Patient or Responsible Party) Date

(Fire Department use only)

Current Account Balance	Adjustment by Fire Department	New Balance

_____

Signature (Shoreline Fire Department) Date