

**PROVIDENCE EVERETT HEALTHCARE CLINIC**  
**CONFIDENTIAL FINANCIAL STATEMENT – REQUEST FOR FINANCIAL ASSISTANCE**

Date: \_\_\_\_\_ Name of responsible party: \_\_\_\_\_  
Patient name: \_\_\_\_\_  
Address of responsible party: \_\_\_\_\_  
Account #: \_\_\_\_\_ Daytime phone: \_\_\_\_\_

**Indicate your family size:** \_\_\_\_\_ Family size refers to anyone listed on your tax return

**Have you been approved for financial assistance from Providence Everett Medical Center** in the last 6 months? Yes \_\_\_\_ No \_\_\_\_

If "yes" do not complete this form. Let the receptionist know that you are already approved for financial assistance with Providence.

**If you answered "no" to the above,** please provide the following information:

**Please list all monthly family income and supply the required documentation**

- \_\_\_\_\_ Patient wages (current pay stubs – last 3 months)
- \_\_\_\_\_ Spouse/custodial parent/guardian wages (current pay stubs – last 3 months)
- \_\_\_\_\_ Social security benefit (copy of your SSA letter)
- \_\_\_\_\_ Public assistance (copy of your award letter)
- \_\_\_\_\_ Worker's comp (copy of your compensation letter)
- \_\_\_\_\_ Alimony or child support (copy of your divorce decree)
- \_\_\_\_\_ Pension, VA, or military retirement (copy of your benefit letter)
- \_\_\_\_\_ Other income (provide proof of income and the type of income)

**\$\_\_\_\_\_ COMBINED MONTHLY INCOME**

**? No income.** You must supply us with a brief note from the person who is helping you with living arrangements. This note needs to be dated and must be signed.

The above statement is being given to Providence Everett Healthcare Clinic because I am unable to pay for the full cost of my care in the clinic and request financial assistance. I understand that the information provided by me is subject to verification by the clinic or its billing office. I understand that any false information provided by me will result in a denial of any financial assistance. Financial assistance is available only after all other forms of reimbursement (Health insurance, Medicaid, or third party insurance) have been exhausted.

\_\_\_\_\_  
Responsible party signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Account representative signature

\_\_\_\_\_  
Date

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**CLINIC STAFF ONLY – DO NOT WRITE BELOW THIS LINE**

Approved for the following:

- \_\_\_\_\_ % of Federal poverty Guideline
- \_\_\_\_\_ Expected payment percent
- \_\_\_\_\_ Expected discount percent (PacLab)

Denied for the following reason(s):

- \_\_\_\_\_ Family income exceeds guidelines
- \_\_\_\_\_ Did not provide requested information
- \_\_\_\_\_ Information was incomplete/inaccurate
- \_\_\_\_\_ Other: