UW Medicine

Financial Assistance MyChart Supplemental Application Form Instructions

This is the supplemental application to upload directly into MyChart. Use this supplement application ONLY if you are applying through your MyChart account for Harborview Medical Center, UW Medical Center-Montlake, UW Medical Center-Northwest, UW Physicians and UW Neighborhood Clinics. If you are submitting by mail, fax, in person or completing a non-English application (Amharic, Chinese, Punjabi, Russian, Somali, Spanish, Vietnamese) you must download and complete the full Financial Assistance application on our website at uwmedicine.org/financialassistance. You can also request an application from the location where you are seeking care.

This is an application for financial assistance (also known as charity care) at UW Medicine. Washington State requires all hospitals to provide financial assistance to people and families who meet certain income requirements. You may qualify for financial assistance based on your family size and income, even if you have health insurance. Assistance is awarded if you meet the financial assistance guidelines which includes your household income is 300% or less of the federal poverty level. You can request more information or refer to our financial assistance website at uwmedicine.org/financialassistance.

What does financial assistance cover? The hospital financial assistance covers appropriate hospital-based services provided by UW Medicine depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

To process your application in MyChart, you must:

Provide us information about your family; fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)

- Provide us information about your family's gross monthly income (income before taxes and deductions)
- Provide documentation for family income and declare assets
- Attach additional information if needed, for example, letters of support to validate your information
- Submit the supplemental form on page 2 and enter additional information into MyChart

UW Medicine will uphold the confidentiality and dignity of each patient. Any information submitted for consideration of financial assistance will be treated as protected health information under the Health Insurance Portability and Accountability Act (HIPAA).

To process your application, you must be a registered patient with a Medical Record Number (MRN):
For Harborview Medical Center, UW Medical Center-Montlake, UW Medical Center-Northwest, UW Physicians and UW Neighborhood Clinics call the Contact Center at 206.520.5000 to register prior to completing your application.

Harborview Medical Center UW Physicians UW Neighborhood Clinics	UW Medical Center-Montlake UW Physicians UW Neighborhood Clinics	UW Medical Center-Northwest UW Physicians UW Neighborhood Clinics
Financial Counseling 325 9th Ave; Mail Stop 359758 Seattle, WA 98104-2499 Phone 206.744.3084 FAX 206.744.5187 M-F 8:00 a.m. – 4:30 p.m. mychart.uwmedicine.org	Financial Counseling 1959 NE Pacific Street; Mail Stop 356142 Seattle, WA 98195-6142 Phone 206.744.3084 FAX 206.598.1122 M-F 8:00 a.m. – 4:30 p.m. mychart.uwmedicine.org	Financial Counseling 1550 N 115th St Seattle, WA 98133-9733 Phone 206.744.3084 FAX 206.598.1122 M-F 8:00 a.m. – 4:30 p.m. mychart.uwmedicine.org

If you have questions and need help completing this application, please contact the facility above where you are seeking care. You may obtain help for any reason, including disability and language assistance. We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income. By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly! You may receive bills until we get your information.

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Financial Assistance – MyChart Supplemental Application Form – Confidential

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Please fill out all information completely. If it does not apply, answer "No" or enter "NA." Attach additional pages if needed.

PATIENT AND APPLICANT INFORMATION			
Patient First Name	Patient Middle Name	Patient Last Name	
☐ **Male** ☐ **Female** ☐ **Other** (may specify _____)	Medical Record No. (MRN)	Patient Birth Date	Patient Social Security No. (optional)
Person Paying Bill (Guarantor)	Relationship to Patient	Guarantor Birth Date	Guarantor Social Security No. (optional)
Mailing Address _____ _____ City State Zip Code			Area Code Phone Numbers (_____) _____ (_____) _____ Email address: _____

SCREENING INFORMATION
Do you need an interpreter? ☐ **Yes** ☐ **No** *If Yes, list preferred language:*
Has the patient applied for Medicaid? ☐ **Yes** ☐ **No** *May be required to apply before being considered for financial assistance*
Does the patient currently have health insurance? ☐ **Yes** ☐ **No**
Does the patient receive state public services such as TANF, Basic Food, or WIC? ☐ **Yes** ☐ **No**
Is the patient currently homeless? ☐ **Yes** ☐ **No**
Is the patient's medical care need related to a car accident or work injury? ☐ **Yes** ☐ **No**

FAMILY INFORMATION

List family members in your household, **including yourself.** "Family" includes people related by birth, marriage, or adoption who live together.

FAMILY SIZE_____ *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					☐ **Yes** ☐ **No**
					☐ **Yes** ☐ **No**
					☐ **Yes** ☐ **No**
					☐ **Yes** ☐ **No**