WACBD
WASHINGTON CENTER FOR BLEEDING DISORDERS

Patient Financial Assistance Program Application

Confidential

Please fill out all information completely. If it does not apply, write "N/A." Attach additional pages.

Screening Information	
Do you need an interpreter? ☐ Yes ☐ No	If yes, preferred language?
Has the patient applied for Medicaid? ☐ Yes ☐ No - *May be required to apply before being considered for financial assistance.*	
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	

Please Note

We cannot guarantee you will qualify for financial assistance.

Once you send in your application, we check all the information and may ask for additional information. Within 14 calendar days after the Financial Assistance Committee receives your completed application and documents, we will notify you if you qualify for assistance.

Patient and Applicant Information		
Patient first name	Patient middle name	Patient last name
Person Responsible for Paying Bill	Relationship to patient	
Mailing Address _____ _____ City State Zip		
Phone Number	Secondary phone number	Email address

Employment status of person responsible for paying bill

☐ Employed (date of hire: _____) ☐ Part-time ☐Full-time ☐ Unemployed (how long unemployed: _____)

☐ Self-employed ☐ Student ☐ Disabled ☐ Retired ☐ Other (_____)

Family Information

List family members in your household. "Family" is (a) Adult persons related by blood or marriage; (b) adult persons who are presently residing together or who have resided together in the past; and (c) persons who have a biological or legal parent-child relationship, including stepparents and stepchildren and grandparents and grandchildren. Family size _____ *Attach additional pages if needed*

All adult family members' income must be disclosed. Sources of Income include, for example:

Wages – Unemployment – Self-employment – Worker's compensation – Disability – SSI – Child/spousal support – Work study programs (students) – Pension – Retirement account distributions – Other (Please explain_____)

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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?
1.					Yes / No
2.					Yes / No
3.					Yes / No
4.					Yes / No
5.					Yes / No

Income Information

Remember: You must include proof of income with your application.

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. If you cannot provide documentation you may submit a written statement describing your income. Please supply the following items for proof of income:

If you are employed:

- Copy of last year's tax return AND
- Copy of two most recent pay-stubs

If you are unemployed:

- Copy of last year's tax return AND
- Copy of last two months bank statements

Expense information

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

Rent/Mortgage $_____ Medical Expenses $_____

Insurance Premiums $_____ Utilities $_____

Other Debt/Expenses $_____ (child support, loans, medications, other)

Additional Information

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss. If you have recently qualified for other financial assistance or aid, including Medicaid, include a copy of the approval letter with your application. We may consider this when reviewing your application.

Patient Agreement	
I understand that Washington Center for Bleeding Disorders may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans. I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance and I may be responsible for and expected to pay for services provided.	
Signature of person applying	Date:
Signature of patient	Date: