WASHINGTON HEALTH SYSTEM

CHARITY CARE APPLICATION

Last Name: _____ **First Name:** _____

Address: _____

City_____ **State:** _____ **Zip code:** _____

Daytime phone number: _____

Number of family members in household: _____

Date applied for Medical Assistance: _____ **Denied**: Yes or No
**Please provide your Medical Assistance determination. *(circle)*

Please provide a complete copy of your most recently filed federal tax return and your last 2 month's bank (checking/savings) statements.

Proof of all household income is required.

Household Income:	**You**	**Spouse**	**Other Members**
Gross Salary/Wages (please provide pay stubs for the last 30 days)	**$**	**$**	**$**
Pension	**$**	**$**	**$**
Social Security Income	**$**	**$**	**$**
Unemployment Compensation	**$**	**$**	**$**
Disability	**$**	**$**	**$**
Child Support and/or Alimony	**$**	**$**	**$**
Interest and/or Dividends	**$**	**$**	**$**
Other (please describe)	**$**	**$**	**$**
Total Income	**$** 0.00	**$** 0.00	**$** 0.00

Please list all medical expenses below:

Medical Expenses		**Amount Owed**
Doctor/Facility		**$**
Doctor/Facility		**$**
Doctor/Facility		**$**
Doctor/Facility		**$**
Doctor/Facility		**$**

If you have additional medical expenses please list on back of form.

APPLICANTS SIGNATURE: _____ **DATE**_____
Please print and sign.

FOR HOSPITAL USE ONLY –DO NOT WRITE BELOW THIS LINE

Reviewed by: _____ Date_____

Annual household income: $_____ Family size per tax return: _____ % FPG: _____

Approved/Denied: _____ Date: _____ Determination letter mailed on: _____