OLYMPIA
MEDICAL CENTER

# Confidential Medical and Financial Assistance Application

| Acct. #: | Patient Name: | SSN: | DOB: |
|---|---|---|---|
| Patient Address: | | Patient Home Phone: | Patient Work Phone: |
| Type of Service: (circle one) **ER OP IP**<br>**Co-Pay Amount: $ _____** | | Service Date: _____/_____/_____ to _____/_____/_____ | |

## SECTION A: MEDICAL ASSISTANCE SCREENING

| | Yes | No |
|---|---|---|
| 1. Is the patient under age 21? | ☐ | ☐ |
| 2. Is the patient over the age of 65? | ☐ | ☐ |
| 3 Is the patient a married parent of a minor child? | ☐ | ☐ |
| If **yes**, answer the following questions: | | |
| a) Does the child(ren) live full time in the home? | ☐ | ☐ |
| b) Does the patient have a 30-day incapacitation? | ☐ | ☐ |
| c) Is the patient the primary wage earner for the household? | ☐ | ☐ |
| 4. Is the patient a single parent of a child under age 21? | ☐ | ☐ |
| 5. Is the patient a caretaker or guardian of a child Under 21? | ☐ | ☐ |
| 6, Is the patient pregnant, or was the admission pregnancy related? | ☐ | ☐ |
| 7. Will the patient potentially be disabled for 12 months? | ☐ | ☐ |
| Answer these questions if the patient answered **NO** to question 1-5. | | |
| a. When did the patient last work? _____ | | |
| b. Is the patient planning to return to work? | ☐ | ☐ |
| If **yes**, when ?_____ | | |
| c. Does the patient have any additional medical problems? | ☐ | ☐ |
| If **yes**, please list all medical conditions. _____ | | |
| _____ | | |
| 8. Is the patient a Victim of Crime? | ☐ | ☐ |
| If **yes**, was a police report filed? | ☐ | ☐ |
| 9. Does the patient have a "COBRA" or insurance policy that the premium has lapsed? | ☐ | ☐ |

## SECTION B: MEDICAL ASSISTANCE SCREENING

| | |
|---|---|
| Responsibility Party: | Relationship to Patient: |
| SSN: | DOB: |
| Home Address: | Phone #: |
| Gross Income: $ | Circle One: ☐ Hourly ☐ Daily ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly |
| Name of Employer: | Hours Per Week: |
| If income is $0/unemployed, what is your means of support? | ☐ Living on Savings/Annuity ☐ Live with parent/family/friends ☐ Homeless ☐ Shelter |

**Total Number of Dependent Family Members in Household: _____**
(*Include patient, patient's spouse, legal guardian, and any children the patient has under the age of 18 living in the home. If the patient is a minor, include mother/father and/or legal guardian, and all other children under the age of 18 living in the home.)*

## SPOUSE

| | | |
|---|---|---|
| Responsibility Party: | SSN: | DOB: |
| Home Address: | | Phone #: |
| Work Address: | | Phone #: |
| Gross Income: $ | Circle One: ☐ Hourly ☐Daily ☐ Weekly ☐ Monthly ☐ Yearly | |

## SECTION C: MEDICAL ASSISTANCE SCREENING

I, _____, hereby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others. _____
Patient/Guarantor Initials

**ATTESTATION OF TRUTH**

I hereby acknowledge all of the information provided herein is true and correct. I understand that providing false information will result in the denial of this Application. Additionally, depending upon local or state statutes, providing false information to defraud a hospital for obtaining goods or services maybe considered an unlawful act. I also acknowledge and consent that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that the Charity Care program(s) is a "Payor of Last Resort" and hereby confirm all prior assignments of benefits and rights, which may include liability actions, personal injury claims, settlements, and any and all insurance benefits which may become payable, for fitness or injury, for which Olympia Medical Center or it's subsidiaries provided care.

_____ _____
PATIENT/GUARANTOR SIGNATURE DATE