Group Health Cooperative
Sponsored Care
PO Box 34584
Seattle, WA 98124-1584

Dear Group Health Patient:

If you are unable to pay your bills, you may qualify for financial help under Group Health Cooperative's Charity Care program. This assistance may help with your costs for medical services received at Group Health Central Hospital on our Capitol Hill campus.

To Qualify

Appropriate hospital-based care is available free of charge to individuals who:

- Received care at Group Health Central Hospital or qualified for Charity Care at a state-licensed hospital where the individual was treated by a **Group Health provider**.
- Have gross personal or family household income that meets Charity Care guidelines for the household size (see chart below).
- Agree to allow Group Health to bill any other insurance or third party payer who may be responsible for all or part of the individual's Group Health expenses.

2016 Charity Care Income Guidelines*	
Household/family size	*Gross monthly income must be less than/equal to:*
1	$2,970
2	$4,005
3	$5,040
4	$6,075
5	$7,110
6	$8,145
7	$9,183
8**	$10,223
**Income figures are 300% of the Federal Poverty Level guidelines as of January 2016* ***for each additional member, add $1,040* *If self-employed, report income after business expenses.*	

How to Apply

- **Complete** the attached Charity Care application – ALL sections on both sides – and sign it. ALL household members 18 or older must sign the application if they are applying for assistance.
- **Provide** income verification for your entire household, including any income earned by dependents, for the 3 months or 90 days prior to your application (whichever is greater).
- **Include** special documents as instructed.
  - Dependents: If your household includes dependent adults, foster children or adopted children, provide guardianship papers or a recent income tax return that lists them as dependents.
  - Release of information – Agent Authorization form: If you want another person to discuss your application, including medical and/or financial information, include the Agent Authorization form (attached) or similar document.

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- **Provide** written proof (an approval letter or write-off billing statement) if you received Charity Care at a non-Group Health hospital and are applying for Group Health doctor fees related to that visit.
- **Is your application complete?** Review the document checklist in Section III of the application to make sure you've completed all the required fields and have included one form of the income verifications listed. **Return** the application and all income verification in the enclosed postage paid envelope, and mail it to us at:

  GHC Sponsored Care
  P.O. Box 34584
  Seattle, WA 98124-1584

  Please do not email your completed application as we cannot guarantee the security of your confidential information if it is emailed. To ensure the privacy of your information, mail the application, or **fax** it to **206-877-0640** to expedite the review process.

What to Expect

The review process may take up to 20 business days.

If your application is not complete, or if you do not provide all of the income verification documents and necessary special documents, we will contact you in writing to request additional information. We will mail you a letter with our decision. If your application is approved, the letter will contain the details of your assistance, including the date(s) approved. If your application is denied, the letter will explain why we made that decision.

What's Next?

Charity Care assistance is temporary so we urge you to do everything you can to obtain further assistance with the cost of your medical care. If you have an ongoing need for financial assistance, and are eligible, you can apply for medical assistance at **Washington Apple Health (Medicaid) (call 1-855-923-4633 or go to http://www.hca.wa.gov/medicaid** or contact the **Washington Information Network (dial 2-1-1)** to find out about other long-term options.

Questions?

If you have questions or need help completing the application, please call Group Health Patient Financial Services at **(206) 901-6089**.

GroupHealth

Group Health Cooperative Charity Care Application

I. APPLICANT / HOUSEHOLD INFORMATION

Please complete all sections of this application and provide income verification documents for all members of your household (see Section III).

Name _____ DOB _____ SS# XXX–XX–_____ Group Health #, if member _____

Spouse _____ DOB _____ SS# XXX–XX–_____ Last 4 digits only Group Health #, if member _____

Mailing Address _____ Email _____

City _____ State _____ Zip _____ Phone # (_____)_____

Marital Status: Single / Married Total Number in Household _____ Number Applying for Financial Assistance _____

I was referred by Group Health by:
- ❑ Social Worker ❑ Customer Service ❑ Business Office
- ❑ Clinic Staff ❑ Behavioral Health Services
- ❑ Patient Financial Services
- ❑ Other _____

Name _____

Facility _____

Please list all household members including you (list additional members on a separate sheet).

Name	Medicare eligible?	Age	Group Health #, if member	Relationship (spouse, child, etc.)	Is this person your financial dependent?	Financial assistance needed ✓

Group Health Charity Care can only be applied to fees for medically necessary services received at Group Health Central Hospital. Group Health cannot assist with bills from a non-Group Health provider.

Continue to Section II and Sign

II. FINANCIAL INFORMATION FOR HOUSEHOLD MEMBERS WHO RECEIVE ANY INCOME

INCOME

Complete this worksheet and return with copies of documentation as indicated below. **If you have questions, call (206) 901-6089 or visit the Group Health Central Hospital Business Office located in the South Building, Wing A1, Room CSB137.**

Monthly Income During the last 3 Months/90 Days	Applicant	Spouse	Children
1. Earnings from all jobs – wages, tips, commissions, etc. *Paystubs from all employers showing gross monthly and YTD income*	$ /mo	$ /mo	$ /mo
2. Social Security benefits / SS Disability / Supp. Security Income *Include a copy of your annual benefit letter or 1099 form*	$ /mo	$ /mo	$ /mo
3. Pension / Retirement / Annuity Income *Include copies of monthly income statement, benefit letter or 1099 form*	$ /mo	$ /mo	$ /mo
4. Unemployment Compensation *Include weekly pay stubs or payment report for the previous 3 months*	$ /mo	$ /mo	$ /mo
5. Other Income *Include amounts received for alimony, child support, foster child benefits, L&I or long-term disability payments, rental income, union or veteran's benefits or other supplemental income* ❑ Alimony / Child Support / Foster child benefits ❑ Injury or illness benefits – L&I or long-term disability ❑ Rental income received ❑ Union or Veteran's benefits ❑ Other (describe)_____	$ /mo	$ /mo	$ /mo
6. Income Subsidies ❑ School grants or loans used for living expenses ❑ Public Assistance (DSHS) money grants (don't include food stamps) ❑ Gifts from friends or relatives (explain in signed note)	$ /mo	$ /mo	$ /mo
7. Self-Employment *Use attached Self-Employment Worksheet to calculate adjusted gross income.*	$ /mo	$ /mo	$ /mo
Total Gross Income	$ /mo	$ /mo	$ /mo

III. DOCUMENTS

Please include with your application one of the following forms of income verification:

- a "W-2" withholding statement;
- pay stubs; include a note explaining any gaps such as pay periods not worked; or list first and last day for each job.if you changed employers
- an income tax return from the most recently filed calendar year;
- forms approving or denying eligibility for DSHS Medicaid and/or state-funded medical assistance;
- forms approving or denying unemployment compensation; or
- written statements from employers or welfare agencies.

If applying on behalf of an adult patient, or, if you would like to contact us on your behalf include a copy of Agent Authorization form or guardianship papers.

If household includes dependent adults, grandchildren, foster children, or other dependents include a copy of your most recent income tax return listing them as dependents.

If someone claims you as a dependent, include a copy of that person's most recent income tax return listing dependents.

If you received no income, include a signed note explaining how you managed during the last 3 months/90 days. Note whether you received free room and board, assistance with bills from family or friends, etc. **List the date, amount and donor for all cash gifts**.

If you are self-employed include a copy of your W9, your most recent income tax return including Schedule C and SE, or any other schedule related to your business.

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I understand that the information I submit is subject to verification by Group Health. I understand that this application may be denied if the request does not meet Group Health Charity Care criteria. I certify that the above information is true and correct.

OR, please check the box below and tell us why you aren't able to provide the documentation we've requested.

☐ I cannot provide the requested documentation because:

- ☐ I do not receive a formal pay stub from my employer.
- ☐ I have no income. (If you check this box, you must provide a written explanation of your financial situation below.)
- ☐ I was not required to file a federal or state tax return for the most recent tax year or I obtained a filing extension.
- ☐ Other. Please provide an explanation for the reason you are not able to provide documentation.

Date _____ **Applicant's Signature** _____

Spouse's Signature* _____

Signatures of Dependents 18 or older* _____

_____

**Required if also applying, (list additional signatures on a separate sheet)*

GroupHealth

Group Health Cooperative
Self-Employment Income Worksheet

If applicable, use this form to report income from your business or partnership for the **three months before** you applied for Charity Care. If your business is operated out of your home, calculate your work-related housing costs according to IRS rules. List this amount below, under "Building." **Please attach a copy of your most recent W-9.**

Name	UBI Number
Business Name	Type of Business
Address	Application Date Range (last 3 months)
City, State, Zip	_____ through _____

Income Worksheet	$ Amount
Month 1:	
Week 1	
Week 2	
Week 3	
Week 4	
Week 5	
Month 2:	
Week 1	
Week 2	
Week 3	
Week 4	
Week 5	
Month 3:	
Week 1	
Week 2	
Week 3	
Week 4	
Week 5	
Total 3-mo business income	$
Subtract total 3-mo expenses (from expense worksheet)	$
ADJUSTED gross 3-mo business income	
Add 3-mo personal draw (from expense worksheet)	
Total gross 3-mo income	

Expenses Worksheet	$ Amount
Building	
Rent/Mortgage	
Utilities (electricity, water, etc.)	
Telephone	
Repairs & maintenance	
Office and administrative expenses	
Printing	
Postage/shipping	
Supplies	
Travel expenses	
Other expenses (average annual expenses)	
Advertising/other selling expenses	
Professional services (accountants, legal costs, etc.)	
Insurance	
Tools & equipment (include lease costs)	
Licenses, trade dues, etc.	
Business loan payments	
Other (please describe):	
Staff/Personnel	
Wages & commissions (exclude self)	
Amount paid to partners in partnership (exclude self)	
Personal draw (self)	
Social Security taxes	
Taxes	
Sales tax	
Business tax (UI, L&I, B&O, etc.)	
TOTAL 3-mo expenses	

RECEIVED

GroupHealth

Group Health Cooperative
Financial Assistance Agent Authorization

I hereby grant the following named individual (my "Agent") a limited power of attorney, to be exercised solely for the purpose of taking such actions on my behalf as are reasonably required to make application for Group Health financial assistance. It is my intent that Group Health Patient Financial Services staff be able to discuss and release financial and/or healthcare information to my Agent for purposes of the financial assistance.

My Agent, with whom the information may be shared, is:

_____ _____
(Name) *(Relationship or Organization)*

_____ _____
(Address) *(Phone Number)*

The information to be shared with my Agent includes, but is not limited to:

- Financial assistance applications and related income verification documents
- Financial assistance decision letter regarding my application
- My correspondence with Patient Financial Services regarding my application, my medical assistance needs, and my eligibility status
- Internal Group Health documentation regarding my medical assistance needs and internal information that pertains to my eligibility for Group Health financial assistance

I understand that I don't have to sign this form to get health care benefits (treatment, payment, or enrollment) from Group Health.

I can revoke this authorization by notifying Group Health Patient Financial Services in writing at the address on the bottom of this page. If I do revoke the authorization, it won't affect any actions that Group Health has already taken based on the form. Once Group Health discloses this material, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.

If my Group Health financial assistance application is approved, this authorization will expire when my financial assistance ends. If my application is not approved, this authorization will expire after 90 days.

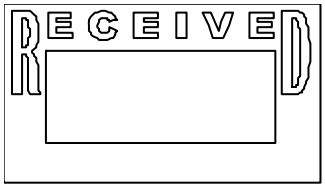
Effective Date_____

I am of legal age, and have read and fully understand this release.

Signature _____ **Date**_____

Printed name_____

Address _____ **Phone** _____



Please return this completed form to:
Group Health Patient Financial Services
PO Box 34584
Seattle, WA 98124-1584

206-901-6089 (Ph) • 206-877-0640 (Fax)

RE: Consumer Name/Number: _____