Individual Written Notice of Financial Assistance

It is the policy of East Olympia Fire District 6 that no person will be denied emergency medical care because of an inability to pay for such services.

East Olympia Fire District 6 will provide needed emergency service without charge or at a reduced cost without discrimination to those persons with documented inadequate or no means to pay for care.

To be eligible to receive needed ambulance transport services without charge or at a reduced cost, you or your family's gross annual income must be at or below levels established by current HHS national poverty guidelines for this area.

You may also qualify for financial assistance from East Olympia Fire District 6 if you have been granted financial assistance by the medical facility to which you were transported.

If you think you may be eligible for Financial Assistance under this policy, please complete and sign the application, attach the required income documentation, or provide a grant of "hospital charity" and submit the completed application packet to:

East Olympia Fire District 6
C/O Billing Services
P.O. Box 3510
Silverdale, WA 98383

You will be notified of the determination made in your request for financial assistance and any reduction in your charges once the Fire Department has reviewed your application.

EAST OLYMPIA FIRE DISTRICT

BLS TRANSPORT FINANCIAL ASSISTANCE APPLICATION

Patient's Name:	
Contact Phone:	
Date of Service:	
Hospital Transported To:	

Responsible Party:	
Name (if different from patient):	
Relationship:	
Current Employer:	
Employed From:	
Previous Employer:	
Spouse Employer:	
Employed From:	
Previous Employer:	

INCOME	Family Member 1	Family Member 2	Family Member 3	Family Member 4
Name:				
Relationship:				
Wages:				
Self-Employment:				
Public Assistance:				
Social Security:				
Unemployment:				
Worker's Comp:				
Child Support:				
Pension/Retirement:				
Other Income:				
TOTAL INCOME:				

Please attach documentation of any listed income such as W-2's, pay stubs, tax returns, or forms approving or denying eligibility from Medicaid and/or state-funded medical assistance, forms approving or denying unemployment compensation or written statements from employers or welfare agencies.

Was *Charity Care* granted by the receiving medical facility? **YES** ☐ **NO** ☐
If yes, please attach documentation of the charity care decision by the receiving medical facility.

The above information is correct to the best of my knowledge. I hereby authorize East Olympia Fire District 6 to verify this information for the purpose of financial assistance eligibility determination.

Signature (Patient, or Responsible Party) *Date*

FIRE DEPARTMENT USE ONLY		
Current Account Balance	**Adjustment by Fire Dept.**	**New Balance**
Signature (East Olympia Fire District 6)		*Date*