Date:

Washington Hospital
Patient Accounting Department
2000 Mowry Avenue
Fremont, CA 94538

Dear _____ Acct.#_____

Washington Hospital understands that there are those in need of financial assistance with regards to their hospital services. I have recently reviewed your account and have determined that you may qualify for our Financial Assistance Program. I have attached an Application for Financial Assistance of which needs to be completed in order to determine eligibility. In an attempt to further process your application please also mail the following documents to me as well. We need both the application and these additional documents in order to process and determine your eligibility.

- A signed copy of your 2025 Federal 1040 Tax Return (including the W-2 forms)
- Copies of the past 6 months' Pay Stubs
- Copy of Driver's License, Passport or other supporting identification
- Return of this letter signed and dated with requested documentation

If you are not able to provide the above documents, please write a letter explaining why the documents are not included. Once the appropriate documentation is received, your account will be placed on hold from any collection activities until final determination has been made. Please be aware that it could take as long as 6 – 12 months until your application is approved or denied. If the requested documentation is not received within 60 days from the date of this letter, all collection activities will resume.

I declare under penalty of perjury that all information given is true and correct to the best of my knowledge and belief. This signature will be legally binding to the accuracy of all requested financial documents including the Federal Tax Return.

Signature: _____ Date:_____

If you have any questions, please contact me directly at 510-818-8645.

Sincerely,

Michelle Thomas
Financial Assistance Coordinator

H.A.: M.Cal Pending Date	DOS:
Balance: $	NPC

Washington Health

Application for Financial Assistance

Please answer all questions. If not applicable, please write N/A.

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1. Patient Account Number	2. Patient Medical Record Number

Section I

3. Patient Name		
4. Date of Birth	5. Social Security Number	
6. Street Address/Apartment Number		
City	State	Zip Code
Phone Number	Phone Number	
7. Drivers License Number		

8.	a. Have you applied for Medi-Cal or AFDC?	☐ yes	☐ no
	If yes, date of application:		
	If yes, name of worker:		
	b. Do you have an application pending?	☐ yes	☐ no
	c. Has your application been denied?	☐ yes	☐ no
9.	Are you under 21 years of age?	☐ yes	☐ no
10.	Are you 65 years of age or older?	☐ yes	☐ no
11.	Are you legally blind?	☐ yes	☐ no
12.	Are you pregnant?	☐ yes	☐ no
13.	Are you now unable, or do you expect to be unable to work for one year or longer?	☐ yes	☐ no
14.	Do you have a minor child under the age of 21 in your home?	☐ yes	☐ no
15.	Are you a student?	☐ yes	☐ no
16.	Do you have Medicare?	☐ yes	☐ no
17.	Do you live in a nursing home?	☐ yes	☐ no
18.	Do you have health insurance?	☐ yes	☐ no
19.	Are you a Veteran or the dependent of a Veteran?	☐ yes	☐ no
	a. Do you have CHAMPUS?	☐ yes	☐ no
	b. Do you have CHAMP/VA?	☐ yes	☐ no

Section II (Assets/Budget)

20. What is the current balance of your Savings Account? $			
21. What is the current balance of your Checking Account? $			
22. Other Assets (if none, please leave blank)	YES	NO	VALUE
Rental Property			$
Other Assets			$
Other Assets			$
Monthly Income	Amount	Source of Income (job, SSI, etc.)	
23. Self	$		
24. Spouse	$		
25. Other	$		
Other	$		
26. Total Gross Income (before taxes) $			
27. If no income, how do you support yourself?			
28. Do you live alone? ☐ YES ☐ NO			
29. Residence Type House Apartment Shelter Other			
30. How many exemptions do you claim on your Income Tax return, including yourself?			

I declare under the penalty of perjury that all information given is true and correct to the best of my knowledge and belief. I agree to notify this hospital of any changes in my financial circumstances and to provide upon request, information verifying my eligibility status. This information may be released to your physician.

Signature	Date
Representative	Date
Interviewer	Date
Comments	

Please be aware that the ER physician, pathologist, radiology, hospitalist services are billed separately from hospital facility charges. This application covers facility charges only.

For Office Use Only

32. Does patient meet indigent income levels for Financial Assistance ☐ YES ☐ NO

Approved for Financial Assistance

_____ _____

Signature *Date*