Application for Financial Assistance

Instructions for Completing the Application for Financial Assistance:

A completed Application for Financial Assistance and proof of income for the past twelve months for the responsible person and spouse are required before an award of Financial Assistance can be made. Proof of income is determined using *any* of the following:

1. Payroll check stubs from past 2 months
2. Most recent IRS tax return
3. Unemployment compensation records
4. Letter of support from individuals providing basic needs
5. Notice of benefits from government programs

All applications are reviewed on a weekly basis, award letters will be sent as soon as determinations are made. All financial assistance award letters will be accompanied by a Payment Plan Agreement. Failure to complete and return the Payment Plan Agreement or to comply with the Payment Plan Agreement will result in collections action.

Any questions regarding the application process or Financial Assistance Policy can be directed to the Business Office of Northwest Pathology, PS at 360-671-5905.

Thank you

Financial Assistance Application
Northwest Pathology, PS
3614 Meridian Street, Ste 100 Bellingham WA 98225
(360) 671-5905

Patient Name:___________________________
Account #:_____________________________

RESPONSIBLE PARTY & SPOUSE

Family Size (including Self, spouse & dependent children under the age of 21) living in the home:______	
Applicant's Name:	Soc. Sec. #
Name of Spouse:	Soc. Sec. #
Mailing Address:	
City/State/ZIP:	
Telephone #	Cell #

APPLICANT'S EMPLOYER'S NAME AND ADDRESS			BUSINESS PHONE
POSITION/TITLE	MONTHLY INCOME - GROSS	MONTHLY INCOME - NET	LENGTH OF CURRENT EMPLOYMENT
SPOUSE'S EMPLOYER'S NAME AND ADDRESS			BUSINESS PHONE
POSITION/TITLE	MONTHLY INCOME - GROSS	MONTHLY INCOME - NET	LENGTH OF CURRENT EMPLOYMENT

HOUSEHOLD INFORMATION

NAME & YEAR OF BIRTH OF ALL PERSONS IN HOUSEHOLD (USE LINES PROVIDED BELOW)	TOTAL # OF PERSONS IN HOUSEHOLD	DO ANY OTHER PERSONS CONTRIBUTE FINANCIALLY TO THE FAMILY? ☐YES ☐ NO IF YES, AMOUNT $_______________

EXPENSES PER MONTH

ASSETS (OWN)	VALUE	LIABILITIES (OWING)	TO WHOM	MONTHLY PAYMENT		BALANCE	
HOME		MORTGAGE/RENT					
AUTO MAKE MODEL YEAR		BANK LOAN					
		AUTO LOAN					
		CREDIT CARDS:					
		OTHER MONTHLY PAYMENTS (LIST)					
BANK ACCOUNTS/OTHER		MONTHLY MEDICAL PAYMENTS					
		FOOD					
		UTILITIES					
			TOTALS				

Certification: I certify that the above-listed information is true to the best of my knowledge and belief. Further, I will make application for any assistance that may be available for payment of my medical bills and I will take any action reasonable necessary to obtain such assistance and will assign or pay to Northwest Pathology, PS the amount recovered for pathology charges. If any information I have given proves to be untrue, I understand that Northwest Pathology, PS may re-evaluate my financial status and take whatever action becomes appropriate.

__________________ Date

____________________________________ Signature

NWP Use Only: Authorized by _________________ Date ___________