



3901 Hoyt Avenue ■ Everett, WA 98201 ■ 425-259-0966

All areas must be completed and all information submitted within 45 days. If all information is not received within 45 days The Everett Clinic billing policy will be followed based on account status.

### FINANCIAL ASSISTANCE FORM

#### PERSONAL

<b>Name:</b> _____	<b>Date of Birth:</b> _____		
<b>Present Address:</b> _____	<b>City:</b> _____	<b>State:</b> _____	<b>Zip Code:</b> _____
<b>Phone number (residential):</b> (____) _____ - _____	<b>Phone number (work):</b> (____) _____ - _____ X _____		
<b>Marital Status:</b> (S) <input type="checkbox"/> (M) <input type="checkbox"/> (D) <input type="checkbox"/> (W) <input type="checkbox"/>	<b>The Everett Clinic Acct #:</b> _____		
<b>Spouse Name:</b> _____	<b>Date of Birth:</b> _____		
<b>Number of Dependents (under 18 years of age):</b> _____			
<b>Name:</b> _____ _____	<b>Date of Birth:</b> _____ _____		

#### PROOF OF HOUSEHOLD INCOME

- One month pay stubs showing Gross Income for all households members
- Unemployment pay stubs
- Social Security Check stubs/ Award letter
- Disability Check stubs / Award letter
- Bank Statements / Proof of direct deposit
- If claiming no income, provide notarized letter from person financially supporting you

#### PROOF OF TAXES

Current Tax Return / Proof of non-filing Transcripts from IRS website [www.irs.gov](http://www.irs.gov)  
Note: Tax Return is not needed if on SSI / Disability. Base amount for non-filing \$25,000

#### All pages of response from DSHS Health care Assistance required.

For application forms, contact your local DSHS Community Service Officer, or call 1-800-562-3022 or online at [www.dshs.wa.gov](http://www.dshs.wa.gov)

I certify that all statements in this application are true and complete. I agree to submit information that you may request concerning my financial status. I assign all benefits from my insurance plan to be paid directly to The Everett Clinic.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Co-Applicant Signature

\_\_\_\_\_  
Date

Please Return This Application to: P.O. Box 5127 Everett, WA 98206