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Family Medicine of Port Angeles, PLLC • 240 W. Front St Ste A • Port Angeles, WA 98362 • (360) 452-7891 • www.fmpa.net

Patient Financial Assistance Program Application

TODAY'S DATE: ________/__________/__________

APPLICANT NAME: ____

ADDRESS: ____

CITY: ____________________________ STATE:________________ ZIP CODE:________________

TELEPHONE NUMBER: (   ) _______-_________

DATE OF BIRTH: ________/_______/________

Family Members: (Please list all household members residing at the above address and their date(s) of birth respectively)

1. ____ DOB:______/_______/_______

2. ____ DOB:______/_______/_______

3. ____ DOB:______/_______/_______

4. ____ DOB:______/_______/_______

5. ____ DOB:______/_______/_______

6. ____ DOB:______/_______/_______

7. ____ DOB:______/_______/_______

8. ____ DOB:______/_______/_______

9. ____ DOB:______/_______/_______

10. ____ DOB:______/_______/_______

The following is required to determine eligibility:

1. Proof of Income (Please attach with this application):
   A. Pay stubs for 4 week period prior for each working household member and
   B. W-2 withholding statements for all employment for the 12 months prior or
   C. Income Tax return from the most recently filed calendar year along with
   D. Forms approving or denying unemployment compensation.
   E. Forms approving or denying eligibility for Medicaid and/or state funded medical assistance.
   F. Social Security Benefits and or Pensions.
   G. Child Support.
   H. Checking and Saving Statements. (Last 3 statements required)

2. Other Resources (Please check):
   A. Do you own your own business? Yes________ No_______
   B. Do you have savings, stocks, bonds, IRA etc? Yes________ No_______
   C. Do you own your own home? Yes________ No_______
      If so, what is the fair market value of your home? $ ___________._____
      *Attach a copy of your last property tax bill statement showing property value.
   D. Do you own other property where you do not reside? Yes________ No_______
   E. Do you have any other source of income? Yes________ No_______
   F. Do you have Washington State Medicaid? Yes________ No_______
      If no, have you applied to Medicaid? Yes________ No_______

If you checked YES for any of the above items in question 2, please explain:

I, THE APPLICANT FOR FINANCIAL ASSISTANCE PROGRAM, AFFIRM THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. I AGREE TO PROVIDE ANY ADDITIONAL INFORMATION AS REQUESTED IN ORDER TO DETERMINE ELIGIBILITY.

Signature: ____ Date:________/ ________/ _________

Relationship if other than the patient: ____

IF YOU HAVE ANY QUESTIONS CONCERNING THIS APPLICATION, PLEASE DIRECT YOUR QUESTIONS TO THE CLINIC ADMINISTRATOR AT 509-682-2511. YOU WILL RECEIVE WRITTEN NOTIFICATION OF OUR DECISION.

****

Do not write below this line – For office personnel use only.

This document was received on __________________(date) by___________________________(Name/Title).

Information verified by ___________________________________

Percent of Federal Poverty Guideline _______________________

Eligible for balance elimination ________Yes ________No

Eligible for balance reduction ________Yes ________No

Balance reduced by $__________. ______

Balance due by patient $__________. ______

Signature ____________________________ Title_____________________ Date____________________

Signature ____________________________ MD_____________________ Date____________________

Date patient notified____________________ Statement sent_____________________

By ________________________

Family Medicine of Port Angeles

Sliding Fee Scale

Annual Income Level

Effective December 1, 2009

Family Size	Class 6 Pays 0%	Class 5 Pays 20%	Class 4 Pays 40%	Class 3 Pays 60%	Class 2 Pays 80%	Class 1 Pays 100%
1	$0 - $10,830	$10,831 - $13,538	$13,428 - $16,245	$16,246 - $18,953	$18,954 - $21,659	$21,660 - UP
2	$0 - $14,570	$14,571 - $18,213	$18,214 - $21,855	$21,856 - $25,498	$25,499 - $29,139	$29,140 - UP
3	$0 - $18,310	$18,311 - $22,888	$22,889 - $27,465	$27,466 - $32,043	$32,044 - $36,619	$36,620 - UP
4	$0 - $22,050	$22,051 - $27,563	$27,564 - $33,075	$33,076 - $38,588	$38,589 - $44,099	$44,100 - UP
5	$0 - $25,790	$25,791 - $32,238	$32,239 - $38,685	$38,686 - $45,133	$45,134 - $51,579	$51,580 - UP
6	$0 - $29,530	$29,531 - $36,913	$36,914 - $44,295	$44,296 - $51,678	$51,679 - $59,059	$59,060 - UP
7	$0 - $33,270	$33,271 - $41,588	$41,589 - $49,905	$49,906 - $58,223	$58,224 - $66,539	$66,540 - UP
8	$0 - $37,010	$37,011 - $46,263	$46,264 - $55,515	$55,516 - $64,768	$64,769 - $74,019	$74,020 - UP

Note: For family units of more than 8 members, add $3,740 for each additional member.

Family Medicine of Port Angeles

Sliding Fee Scale

Monthly Income Level

Effective December 1, 2009

Family Size	Class 6 Pays 0%	Class 5 Pays 20%	Class 4 Pays 40%	Class 3 Pays 60%	Class 2 Pays 80%	Class 1 Pays 100%
1	$0 - $903	$904 - $1,129	$1,130 - $1,355	$1,356 - $1,580	$1,581 - $1,805	$1,806 - UP
2	$0 - $1,214	$1,215 - $1,518	$1,519 - $1,821	$1,822 - $2,125	$2,126 - $2,427	$2,428 - UP
3	$0 - $1,526	$1,527 - $1,908	$1,909 - $2,289	$2,290 - $2,671	$2,672 - $3,051	$3,052 - UP
4	$0 - $1,838	$1,839 - $2,298	$2,299 - $2,757	$2,758 - $3,217	$3,218 - $3,675	$3,676 - UP
5	$0 - $2,419	$2,150 - $2,686	$2,687 - $3,224	$3,225 - $3,761	$3,762 - $4,297	$4,298 - UP
6	$0 - $2,461	$2,462 - $3,076	$3,077 - $3,692	$3,693 - $4,307	$4,308 - $4,921	$4,922 - UP
7	$0 - $2,773	$2,774 - $3,466	$3,467 - $4,160	$4,161 - $4,853	$4,854 - $5,545	$5,546 - UP
8	$0 - $3,084	$3,085 - $3,855	$3,856 - $4,626	$4,627 - $5,397	$5,398 - $6,167	$6,168 - UP

Note: For family units of more than 8 members, add $312 for each additional member.