MT BAKER IMAGING and
NORTHWEST RADIOLOGISTS

PLEASE READ BEFORE CONTINUING: If any of the below circumstances apply to you, you are ineligible for assistance under our current policy and need not proceed with your application:

- If you are a Medicare/Medicare Advantage plan member (high contractual discount plans, which make members ineligible for further discount)
- If you are a Health Share plan member (these types of plans are not health insurance plans and are not accepted by Mt Baker Imaging)
- If you have an active collections balance on file (requires resolution with Merchants Credit Association @ 425-643-2613 before financial assistance eligibility can be considered)

FINANCIAL ASSISTANCE APPLICATION

Mt. Baker Imaging/Northwest Radiologists offers a Financial Assistance Program in accordance with federal guidelines to individuals who meet certain income and eligibility requirements. Medical services are provided at a reduced cost when it has been determined that all eligibility requirements have been met.
Please return the following information with the enclosed Application, as well as applicable documentation listed on page three:

- Last year's income tax return.
- Pay stubs for the last three months or YTD information for all employers.
- If you are not employed, please provide a copy of any letters awarding benefits such as Social Security income, disability benefits, pensions, etc.

Please read all of the terms and conditions contained in the accompanying application for financial assistance regarding services received at Mt. Baker Imaging/Northwest Radiologists. Should you then determine to apply for financial assistance, please complete the entire application and return it to Mt. Baker Imaging. If there is additional information you would like us to consider when reviewing your application, please provide that to us in writing so we can review it with your other documentation.

Definitions:

- **Guarantor** is the person financially responsible for the bill(s).
- **Household** can be defined as one of the following:
  - Guarantor
  - Guarantor and spouse
  - Guarantor's children/minor dependents and step-children up to age 18
- A **Household** does **NOT** include:
  - Roommates
  - Extended family members, such as aunts, uncles, cousins, parents, etc.
  - Guarantor's unmarried partner if they do not have a child together
  - Children of the unmarried partner

This is an application, not a guarantee of assistance. Your request will be considered once the application is submitted. Within 14 business days after we receive your completed application and supporting documentation, we will notify you in writing if you qualify for assistance or if additional information is required. If you have any questions, please call our Business Office at (360) 255-2220.

Please mail, fax, or e-mail your completed application and supporting documentation to:

Mt Baker Imaging, LLC
Attn: Business Office
P.O. Box 30650
Bellingham, WA 98228-2650
E-mail: financialassistance@nwrads.com
Fax: (360) 594-4012

PATIENT AND APPLICANT INFORMATION

Patient or Guarantor Name as it appears on the bill: _____

Home Address: _____
Street City State Zip Code

Mailing Address: _____
(If different from above) Street City State Zip Code

Home Phone: _____ **Work or Cell Phone:** _____

Please list all family members living in this Household including you (as defined on page one). Attach copies of most recent income tax return(s) and last three months of pay stubs for all Household members 18 years or older.

Name	Date of Birth	Relationship to patient	If 18 years or older: Employer(s) name or source of income	If 18 years or older: Total gross monthly income (before taxes)
1		Patient		
2				
3				
4				
5				
6				
7				
8				

SCREENING INFORMATION

Please answer all of the following questions for your Household (see Definitions on page one). **Provide supporting documentation for every identified source of income. Income verification is required to determine financial assistance eligibility.** All household members 18 years or older must disclose their income. If you cannot provide documentation, you may attach a written signed statement describing your income.

1. Are you covered by a health insurance plan, catastrophic health plan, or healthcare sharing program?
   ____ Yes/who is the payer? _____
   ____ No/not applicable

2. Have you been employed this year?
   ____ Yes/provide a copy of your most recent pay stubs for ALL employers showing YTD gross income for the last three months.
   ____ No/explain how you have supported yourself on page four.

3. Did you file a Federal Income Tax return for last year?
   ____ Yes/provide a copy of your Income Tax Return or W-2(s).
   ____ No/provide a written explanation on page four.

4. Are you self-employed?
   ____ Yes/provide a profit and loss statement for the past 12 months.
   ____ No/not applicable

5. Do you receive Social Security benefits?
   ____ Yes/provide a statement from Social Security showing your monthly benefit amount.
   ____ No/not applicable

6. Have you collected Unemployment compensation in the current year?
   ____ Yes/provide a printout from your local Employment Office showing the amount of all benefits received in the current year.
   ____ No/not applicable

7. Do you receive Disability income benefits?
   ____ Yes/provide a printout from Disability showing the amount of all benefits received in the current year.
   ____ No/not applicable

8. Do you receive Food Stamp Benefits?
   ____ Yes/provide a copy of your current Food Stamp Approval letter.
   ____ No/not applicable

9. Do you receive child support or alimony?
   ____ Yes/provide supporting documentation of monthly amount received.
   ____ No/not applicable

10. Did you receive the services because of a motor vehicle accident (MVA)?
    ____ Yes/if you or the other party had MVA insurance, who is the MVA payer? _____
    ____ No/not applicable

11. If you have no proof of income or no income, please provide a written explanation on page four.

OTHER SOURCES OF MONTHLY INCOME FOR ALL ADULT HOUSEHOLD MEMBERS: PLEASE PROVIDE SUPPORTING DOCUMENTATION

Public Assistance/TANF	$ _____	Unemployment Benefits	$ _____
Food Stamps	$ _____	Disability Benefits	$ _____
Social Security	$ _____	Pension/Annuities	$ _____
Workers' Compensation	$ _____	Dividends/Interest	$ _____
Rental Income	$ _____	Child Support/Alimony	$ _____
Other Income	$ _____	VA Benefits/ Military Allotments	$ _____

ADDITIONAL INFORMATION

Please use this section if you have additional information that you would like us to know as we consider your application, such as seasonal or temporary income, financial hardship, or personal loss.

TERMS AND CONDITIONS

I understand the terms and conditions of receiving financial assistance are:

1. To be considered timely and avoid account balance progression, Financial Assistance applications must be completed within 30 days of your 1st billing statement.
2. Please note that the Financial Assistance guidelines for Mt. Baker Imaging and Northwest Radiologists differ from those offered by PeaceHealth – your eligibility and approval for the Bridge program with PeaceHealth is not a guarantee of eligibility for Financial Assistance or qualification for a discount level specific to Mt. Baker Imaging or Northwest Radiologists.
3. If you have an outstanding collection balance with our collection agency, Merchant's Credit Association, any current services will not be eligible for our Financial Assistance Program.
4. If Financial Assistance is approved, discounts are applied to outstanding balances only and after all other forms of payment have been exhausted. Financial Assistance is secondary to all other sources of payment and if you are insured, your insurer may have already applied contractual discounts to your services that are equal to or even greater than the discount percentage for which you could be approved. The insurer's discounts to your services will be counted towards the financial assistance percentage that could be awarded to you. Patients with healthcare sharing programs are required to provide payments and/or proof of non-payment with corresponding explanation of benefits. We are not able to adjust your account balance until we have received the appropriate documents.
5. Patient accounts must be kept current with payment or payment arrangements during the application process. No portion of any patient payments made during this process will be refunded. This *no refund* part of our policy is regardless of the Financial Assistance Program eligibility date that may ultimately be assigned for you. If you are determined to be eligible for Financial Assistance, your program eligibility date will be clearly outlined in your approval letter.
6. Eligibility expires six months from the first day of the month in which eligibility is granted. A new application must then be submitted and approved for additional services.
7. If additional information is requested or the application is incomplete, you will have 14 days to submit required information or the application is considered denied.
8. Account balances of less than $25.00 are not eligible for financial assistance.
9. Upon approval, payment of the full discounted amount must be made upon receipt of the first adjusted statement. If you are unable to pay the full amount in excess of $75.00, the remaining balance may qualify for eligibility in the Payment Plan program.
10. Failure to pay in full or set up a payment plan within 30 days of the date of your 1st adjusted statement may result in the financial assistance discount being reversed and the full balance being sent to a collections agency.
11. If you are uninsured and financial assistance is denied or you are ineligible, there may be an opportunity to qualify for a 10% discount from billed charges if full payment is made on the balance upon being informed that you are ineligible for the financial assistance program.
12. If you are uninsured and choose to pay in full for your service at check-in, you may be eligible for a 10% time of service discount. If on your date of service you choose to make payment towards your exam and are later determined to be eligible for financial assistance, your payment will not be refunded and financial assistance eligibility will be honored moving forward.

I hereby certify that all of the information provided in the above application is correct and complete to the best of my knowledge. The information provided is subject to verification by any means Mt. Baker Imaging/Northwest Radiologists deem necessary. I understand that knowingly providing false information on my application will result in a denial of and/or reversal of financial assistance granted and prevent me from any future financial assistance eligibility with Mt Baker Imaging/Northwest Radiologists.

_____ _____

Signature of Person Applying Date