# Financial Assistance (Please flip over for application)

Carol Milgard
Breast Center

4525 South 19th Street
Tacoma, WA 98405
(253) 759-2622

## Medical Imaging is a Necessity, Not a Luxury

The Carol Milgard Breast Center is committed to providing exceptional services to ALL patients in our community, regardless of ability to pay. A generous sliding fee scale is available for our patients who meet eligibility criteria. In some cases there may be no fees applied for services received. In any circumstance, please do not delay your imaging exam because you are concerned about payment.

## Why the Breast Center?

With flexible payment plans and board-certified physicians who specialize in breast imaging, the Carol Milgard Breast Center is dedicated to providing you with the highest quality care. We never charge a facility fee, which can raise the price of your bill. We also understand that some insurance policies do not cover every type of imaging service. To make sure you get the care you need, the breast center offers:

- Competitive pricing
- Same-day exam discounts
- Payment plans without finance fees or interest charges
- A single bill, with all imaging costs having been quoted up front
- Financial assistance for eligible patients, including non-U.S. citizens
- Grant matching from our owner organizations, Virginia Mason Franciscan Health and MultiCare Health System

## Financial Assistance at the Carol Milgard Breast Center

Before you apply for financial assistance at the breast center, we encourage you to first attempt to enroll in an insurance plan.

Please note: Qualification for a health insurance program will not bar you from participating in our financial assistance program. Our program may cover the deductible or coinsurance, if eligible, and may cover charges of participants not eligible for insurance.

If you think you might be eligible for financial assistance, please fill out this Financial Aid Application and return it to the breast center, along with any supporting documents, at least 48 hours prior to your appointment. Please note that the entire application must be filled out. An incomplete application will result in the delay of eligibility. You can also fax it to (253) 680-3558 or mail it to:

TRA Medical Imaging/CMBC, Attention: Financial Aid
PO Box 1535
Tacoma, WA 98401

For assistance with this application, exam quotes or to set up a payment plan, please contact a Financial Counselor by calling (253) 680-3485, Monday through Friday, 8:00 a.m. - 4:30 p.m. Interpretive services are also available via conference call for non-English speaking patients.

# Financial Aid Application for the Carol Milgard Breast Center

Please complete this application and return it with supporting documents to our office at least 48 hours prior to your scheduled appointment.

1. Patient information

Patient name _____ Birthdate ____/____/____ MRN _____

Home phone _____ Cell phone _____

Address _____

2. Do you have health insurance? ____ YES ____ NO If you marked "NO," have you applied for insurance coverage through either private insurance or the Washington Healthplanfinder? ____ YES ____ NO Please explain why you don't have insurance. _____

_____

3. Have you been granted financial aid from any MultiCare or Virginia Mason Franciscan Health entities? ____ YES ____ NO If YES, skip to Step 7 to sign this application. In addition to the signed application, please provide a copy of the current letter of determination from the other organization in place of income documentation.

4. Spouse or parent (if applicant is a minor/dependent)

Name _____ Cell phone _____

Home phone _____ Address _____

5. Please include the last 3 months of pay stubs, W2, and other income statements along with this application.

| Income (monthly totals) | Patient | Other family income |
|---|---|---|
| Wages | | |
| Self-employment | | |
| Public assistance | | |
| Unemployment compensation | | |
| Workers' compensation | | |
| Alimony | | |
| Child support | | |
| Pension or retirement | | |
| Interest income | | |
| Rental property income | | |
| Other income (detail) | | |
| | | |
| | | |
| Total income | | |

If there was no income, please explain in detail by submitting a letter. If someone else besides a spouse or partner is providing for you, please have them write a letter stating how they help you financially. The letter must also include contact information for the person supporting you.

6. List all dependents in your household, including your spouse or partner

| Name | Relationship | Age | Name | Relationship | Age |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
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7. The above information is true and correct to the best of my knowledge. I understand that providing false or incomplete information may delay or stop my benefits. It can also cause an overpayment of benefits that I must repay and may result in penalties. I authorize Carol Milgard Breast Center to verify any of the above information and grant permission for its release to Carol Milgard Breast Center for the purpose of financial assistance eligibility determination. I swear under penalty of perjury I have given true, complete information.

_____

SIGNATURE (PERSON MAKING REQUEST) DATE

This information is confidential. Fax to (253) 680-3558 or mail to TRA Medical Imaging/CMBC, Attention: Financial Aid, PO Box 1535, Tacoma, WA 98401. For questions or assistance, please call (253) 680-3485.