DIAGNOSTIC IMAGING NW

A MULTICARE HEALTH SYSTEM AND TRA MEDICAL IMAGING PARTNERSHIP

FINANCIAL ASSISTANCE AT DIAGNOSTIC IMAGING NORTHWEST

MEDICAL IMAGING IS A NECESSITY, NOT A LUXURY

Diagnostic Imaging Northwest is committed to the treatment of all patients, regardless of ability to pay. We offer financial aid based on the current Federal Poverty Guidelines. To use this program, the recipient must first use any medical benefits they have, such as private insurance, Medicare, Medicaid or other health care program. Our program may cover the deductible, copay or coinsurance, if eligible, and may cover charges of participants not eligible for insurance or covered by another health care program.

IF YOU QUALIFY, OUR PROGRAM OFFERS

- Financial assistance for services performed at any DINW facility
- Sliding-scale fees based on income eligibility
- Reasonable payment plans
- Navigation to qualified affordable health plans

AFFORDABLE CARE

With national changes in health care, more people than ever before are now eligible for low-cost or subsidized health insurance. Middle-income and low-income individuals and families generally qualify. If you have not applied for this option, please visit their website to learn more: www.wahealthplanfinder.org. Our financial assistance program may cover the deductible or coinsurance for these plans.

FINANCIAL AID GRANT MATCHING

Diagnostic Imaging Northwest honors financial aid grants from certain health care entities. If you have been granted aid by another health care organization, you may not need to complete the entire application. Instead, please send a copy of the current aid letter with this application and we will provide assistance at the same level, if applicable.

FINANCIAL COUNSELORS

Phone: (253) 841-4353, ext. 5210

Fax: (253) 680-3558

Mailing Address

Diagnostic Imaging Northwest
Attention: Financial Aid
P.O. Box 1535
Tacoma, WA 98401

WE HONOR GRANTS FROM

- Capital Medical Center
- Evergreen Hospital Medical Center
- Franciscan Health System
- HealthPoint
- MultiCare Health System
- Overlake Hospital Medical Center
- Providence and Swedish
- Sea Mar Community Health Centers
- Seattle Cancer Care Alliance
- Thurston County Project Access
- UW Medicine /Valley Medical Center
- Virginia Mason

Please contact us if your aid was granted by any of the organizations listed above and if you have questions about our financial programs.

Financial Aid Application

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

1. Patient name _____ Birthdate _____

Home phone _____ Cell phone _____

Address _____
NUMBER AND STREET CITY, STATE, ZIP

2. Do you have health insurance? ____ Yes ____ No If you marked "No," have you applied for insurance coverage through the Washington Healthplanfinder? ____ Yes ____ No Please explain: _____

_____

3. Have you been granted financial aid from another health care organization? ____ 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 a completed application.

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

Name _____ Cell phone _____

Home phone_____ Address_____
NUMBER AND STREET CITY, STATE, ZIP

5. Please provide your most recent pay stubs, W2, and other income statements.

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 _____

_____

_____

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

Name	Relationship	Age	Name	Relationship	Age

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 Diagnostic Imaging Northwest to verify any of the above information and grant permission for its release to Diagnostic Imaging Northwest 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 or mail form to Diagnostic Imaging Northwest, Attention Financial Aid Services.

For questions or assistance, please call our Financial Counselors.