



## SAN JUAN ISLAND EMERGENCY MEDICAL SERVICE

c/o Systems Design  
PO Box 3510  
Silverdale, WA 98383

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### Individual Written Notice of Financial Assistance

It is the policy of San Juan Island Emergency Medical Service that no person will be denied needed emergency medical care because of an inability to pay for such services.

San Juan Island Emergency Medical Service will provide needed emergency services without charge or at a reduced charge and without discrimination to those persons with no or inadequate means to pay for needed care.

To be eligible to receive needed ambulance services without charge or at a reduced charge, you or your family's annual income must be at or below certain levels established by national poverty guidelines for this area.

If you think you may be eligible for Financial Assistance, please complete and sign the application **on the reverse side of this page** and provide the following supporting documents:

1. Copy of pay stubs for the last 3 months from your last place of employment.
2. Verification of your current employment/unemployment status.
3. A copy of your tax returns (or W-2 forms, at least) for the previous year. Returns or W-2 forms for the previous 2 years are preferred.
4. Disclosure of available credit on all credit cards.
5. Denial from your county assistance program.

Please mail your Financial Application and all supporting documents to:

San Juan Island Emergency Medical Service  
c/o Systems Design  
PO Box 3510  
Silverdale, WA 98383-3510

You will be notified of any reduction in your bill when San Juan Island Emergency Medical Service has reviewed your application.

THIS SECTION TO BE COMPLETED BY BILLING AGENCY/ San Juan Island Emergency Medical Service	
Patient Name:	Incident Date:
<b>Two signatures required (Chief/District Secretary):</b>	
1)	2)
Comments	

**FINANCIAL ASSISTANCE APPLICATION**

**San Juan Island Emergency Medical Service**

c/o Systems Design West Billing Services  
P.O. Box 3510, Silverdale, WA 98383

Phone: (360) 394-7010 or (800) 238-9398  
Fax: (360) 697-1659

RESPONSIBLE PARTY		
Name:	Marital Status [ ] Single [ ] Married [ ] Widowed [ ] Divorce	Social Security Number
Street Address	City, State, Zip Code	How long at this address?
Employer's Name (if employed, how long?)	Employer Address	Business Phone No.
Position / Title	Monthly Income—Gross	Monthly Income--Net
SPOUSE		
Name:		Social Security Number
Street Address	City, State, Zip Code	How long at this address?
Employer's Name (if employed, how long?)	Employer Address	Business Phone No.
Position / Title	Monthly Income—Gross	Monthly Income--Net
MISCELLANEOUS INCOME PER MONTH		
INCOME SOURCE **[Please see Notes below on documentation]	AMOUNT (per month)	COMMENTS
Public Assistance (Per Month)	\$	
Social Security Income (Per Month)	\$	
Unemployment Compensation (Per Month)	\$	
Worker's Compensation (Per Month)	\$	
Alimony / Child Support	\$	
Pension, Retirement Income	\$	
Dividends, Interest	\$	
Savings/Checking	\$	
Other Income (Please Explain)	\$	
OTHER PERTINENT INFORMATION		
List any other information that you feel may influence a decision regarding your account:		
<b>**Note</b> the source of your income listed and what type of documentation you are providing. Examples of documentation you may use to support your income amounts recorded above would be: paycheck stubs, income tax return, W-2s, letter from employer, award letter from DSHS, VA or Social Security benefit determination letter, worker's compensation award notice, verification of child support through copy of decree, or actual check from supporting parent.	In completing this financial statement, I hereby affirm that the above statements are correct and complete, and I give my consent to further verification by San Juan Island Emergency Medical Service or its agents.	
	Signature	Date

Current account balance	Adjustment (by District)	New Balance

\_\_\_\_\_  
**Signature (District)**

\_\_\_\_\_  
**Date**