



CITY OF MERCER ISLAND

Fire Department
C/O Billing Office
PO Box 3510
Silverdale, WA 98383-3510
(206) 275-7607 | Fax: (206) 275-7970

Individual Written Notice of Financial Assistance

It is the policy of Mercer Island Fire Department that no person will be denied needed emergency medical care because of an inability to pay for such services.

The Fire Department 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**, attach documentation for any listed income or grant of "hospital charity," and send to the address below or email mi_fire@mercerisland.gov:

Mercer Island Fire Department
PO Box 3510
Silverdale, WA 98383-3510

You will be notified of any reduction in your bill once the Fire Department has reviewed your application.

Patient's Name	
Date of Service	
Transported to	

Responsible Party		Contact Phone:
Name		Mailing Address:
Relationship		
Current Employer		
Employed From		
Previous Employer		
Spouse Employer		
Employed From		
Previous Employer		

Income	Family Member 1	Family Member 2	Family Member 3	Family Member 4
Name				
Relationship				
Wages				
Self-Employment				
Public Assistance				
Social Security				
Unemployment				
Worker's Comp.				
Alimony				
Child Support				
Pension/Retirement				
Dividend Income				
Rental Prop. Income				
Other Income (detail)				
Total Income				

Please attach documentation of any listed income such as W-2's, pay stubs, tax returns, forms approving or denying eligibility from Medicaid and/or state funded medical assistance, forms approving or denying unemployment compensation or written statements from employers or welfare agencies.

Was charity care granted by the receiving medical facility? Yes No

Please attach documentation of charity-care decision by the receiving medical facility.

I, _____, certify (or declare) under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct. I authorize City of Mercer Island to verify the above information for the purpose of financial assistance eligibility determination.

Signature (Patient or Responsible Party)

Date and Place

Family Size

Current account balance	Adjustment (by Fire Dist.)	New Balance

Signature (Fire Department)

Date