FINANCIAL ASSISTANCE APPLICATION

Financial Counselor: 855-271-2416
Fax: 253-680-3558

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

MEDICAL IMAGING IS A NECESSITY, NOT A LUXURY

TRA Medical Imaging 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 are interested in financial assistance, please fill out this application and mail or fax it with any supporting documents at least 48 hours prior to your appointment. Financial Counselors are available to answer your questions and assist you through this application process.

If you qualify, our program offers:

- Financial assistance for services performed at any TRA-managed 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

TRA Medical Imaging 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. If your aid was granted by an organization that isn't listed below, please contact us.

We Honor Grants From:

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

For questions or assistance, please call toll-free (855) 271-2416, option 1.

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

1 Patient Information

Patient Name _____ Date of Birth _____

Home Phone _____ Cell Phone _____

Address _____

2 Do you have health insurance?

❑ Yes ❑ No If you marked "No" have you applied for coverage through the Washington Healthplanfinder? ❑ Yes ❑ No If you marked "No", please explain: _____

_____

3 Have you been granted financial aid from another health care organization?

❑ Yes ❑ No If you marked "Yes" skip to step 7 of 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

_____

Home Phone _____ Cell Phone _____

Address _____

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

Income (monthly totals)	Patient	Other Family Income
Wages		
Self-employment		
Public Assistance		
Unemployment		
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 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 TRA Medical Imaging to verify any of the above information and grant permission for its release to TRA Medical Imaging for the purpose of financial assistance eligibility determination. I swear under penalty of perjury I have given true, complete information.

Signature _____ **Date** _____

This information is confidential. Fax to (253) 680-3558 or mail to: TRA Medical Imaging, Attention Financial Aid Services, PO Box 1535, Tacoma, WA 98401. For questions or assistance, please call toll-free (855) 271-2416, option 1.