## Attestation of Income for Insured Patient to Receive Financial Assistance, 2012-2017

If you received care from a CHI hospital from 2012 through 2017, please complete the following form regarding your family income in order to determine your eligibility for payments resulting from the Washington Attorney General's 2019 settlement.

| Patient's Name:   |                               |                                |
|---|-------------------------------|--------------------------------|
| Patient's Date of Birth:  | <u></u>                       |                                |
| Full name of responsible party (if not patie                                  | ent):                         | <u>-</u>                       |
| Relationship of responsible party to patie                                    | nt:                           |                                |
| Hospital where care was received:   |                               |                                |
| Approximate date care was received:   |                               |                                |
| Contact phone number:   |                               |                                |
| Contact email (optional):   |                               |                                |
| Contact mailing address:  |                               |                                |
| I certify that at the time the patient name was and family size               | -                             |                                |
| reasonable search and am not able to local income.                            | ate further documentation of  | the patient's household/family |
| I certify (or declare) under penalty of perj<br>foregoing is true and correct | ury under the laws of the Sta | te of Washington that the      |
| Signature of responsible party  | Date                          | Place Signed                   |
| 200% of Federal Poverty Guidelines - 201                                      | 7                             |                                |

| Household/family size | Annual household income must have been less than or equal |
|-----------------------|---|
|                       | to at the time of treatment                               |
| 1                     | \$24,120  |
| 2                     | \$32,480  |
| 3                     | \$40,840  |
| 4                     | \$49,200  |
| 5                     | \$57,560  |
| 6                     | \$65,920  |
| 7                     | \$74,280  |
| 8                     | \$82,640  |