

Mat-Su Regional Medical Center

Subject:	Originally Issued	<u>2/1998</u>
FINANCIAL ASSISTANCE POLICY	Date of Revision	<u>11/2015</u>
	Date of Revision	<u>02/2018</u>

POLICY STATEMENT:

In order to serve the health care needs of our community and to comply with the requirements of its Operating Agreement, **Mat-Su Regional Medical Center** will provide financial assistance to patients without financial means to pay for *Inpatient, Outpatient and Emergency Room services provided by the hospital*. Financial assistance may cover all or part of the costs of care that patients do not have the financial means to pay, but are limited to emergency and medically necessary services only. For purposes of this policy, "medically necessary" services are those that meet Medicare medical necessity criteria.

Financial assistance will be provided to all patients without regard to race, creed, color, or national origin and who are classified as financially indigent or medically indigent according to the hospital's eligibility criteria, which are set forth in this Financial Assistance Policy. If at any time the assistance provided pursuant to this policy fails to satisfy or demonstrates a trend that would result in a failure to satisfy the Operating Agreement, the Hospital shall promptly adopt revisions that can be expected to remedy such a failure, and submit those revisions to the Board of Directors for ratification.

PURPOSE:

To properly identify those patients who are financially indigent or medically indigent, who do not qualify for state and/or federal government assistance or other forms of assistance, and to provide financial assistance with their Inpatient, Outpatient and Emergency Room medical expenses consistently with the guidelines for financial assistance.

ELIGIBILITY FOR CHARITY CARE

1. FINANCIALLY INDIGENT:

- A. A financially indigent patient is a person who is accepted for care with no obligation or a discounted obligation to pay for services rendered based on the hospital's eligibility criteria as set forth in these Policy Guidelines.
- B. To be eligible for financial assistance as a financially indigent patient, the patient's total household income shall be at or below 400% of the current Alaska Federal Poverty Income Guidelines. The hospital may consider other financial assets and liabilities of the person when determining eligibility.
- C. The hospital will use the most current Alaska Federal Poverty Income Guidelines issued by the U.S. Department of Health and Human Services to determine an individual's eligibility for financial assistance as a financially indigent patient. The Alaska Federal Poverty Income Guidelines are published in the Federal

Register in January or February of each year and for the purposes of this Process will become effective the first day of the month following the month of publication.

- D. Uninsured patients who do not apply for financial assistance or who do not qualify for financial assistance are eligible for a discount based on the hospital uninsured discount policy.
- E. The hospital, with Board of Directors approval, may adjust the eligibility criteria from time to time based on the financial resources of the hospital and as necessary to meet the health care needs of the community.

2. PRESUMPTIVE ELIGIBILITY:

- A. Patients covered by out of state Medicaid where the hospital is not an authorized provider and where the out of state Medicaid enrollment or reimbursement makes it prohibitive for the hospital to become a provider, will be eligible for financial assistance upon verification of Medicaid coverage for the service dates. No other documents will be required in order to approve the application for assistance. The patient will not be required to make a formal application for assistance. The hospital may submit the application and verification of coverage as proof of qualification.
- B. Medicaid patients who exhaust their coverage and benefits will also be eligible for financial assistance for those medically necessary hospital services.
- C. Deceased patients with no estate will automatically qualify for financial assistance.

MEDICALLY INDIGENT:

- A. A medically indigent patient is a person whose medical bills after payment by third party payers exceed a specified percentage of the person's annual gross income as defined herein and who is unable to pay the remaining bill.
- B. To be eligible for financial assistance as a medically indigent patient, the patient must owe, after payment by third party payers, an amount on medical bills for the prior 12 month period that exceeds 25% of the patient's annual gross income and the patient must be unable to pay the remaining bill. The hospital may consider other financial assets and liabilities of the person when determining ability to pay.
- C. A determination of the patient's ability to pay the remainder of the bill, or portion of the bill, will be based on whether, in the hospital's judgment, the patient reasonably can be expected to pay the account, or portion thereof, over a 3-year period.
- D. The patient shall be eligible for a discount for any amount beyond what the patient is expected to pay over a 3-year period, after meeting all other criteria.
- E. If the hospital determines that a patient had the ability to pay the remainder of the bill, such a determination does not prevent a reassessment of the patient's ability to pay at a later date should there be a change in the patient's financial status.

LIMITATIONS ON PATIENT CHARGES

- A. For emergency and medically necessary care, the hospital will not charge any patient who is determined to be eligible for financial assistance more than the "AGB percentage" (amounts generally billed) of its full price before any contractual allowances, discounts, or deductions for the services provided as a part of such care. The amount billed to the patient determined to be eligible for financial assistance will not exceed the AGB percentage.
- B. The AGB percentage used in complying with this section is determined using the look-back method, as those methods are defined in federal tax law. The hospital has prepared a document, which is available at www.matsuregional.com, on the "Community" tab, setting forth the AGB percentages used for the current year, and describing in detail the method through which those AGB percentages are calculated.

PARTICIPATION IN THIS POLICY

- A. This policy covers all emergency and medically necessary care provided by the hospital and its employees.
- B. Some third-party health care providers that provide emergency and medically necessary care within the hospital under contract to the hospital may not extend financial assistance in accordance with this policy, choosing instead to apply their own policies for financial assistance.
- C. A list of all of the third-party health care providers that provide emergency and medically necessary care within the hospital under contract is available at www.matsuregional.com, on the "Community" tab. This list indicates whether or not each third-party health care provider follows the criteria and procedures for extending financial assistance set forth in this policy.

THE PROCESS

1. Publicity for Assistance Program:

- A. All hospital facilities maintain posted signs, in English, *Exhibit A* and Russian, *Exhibit B*. One sign shall be posted in each admitting office; one in the emergency and urgent care lobbies; and one in each Financial Counselor office that inform customers that financial assistance is available and what the criteria for assistance are.
- B. All self-pay patients are asked to complete the Financial Assistance form "FA", *Attached in English and Russian* during the registration or financial counseling process.
- C. The hospital will provide written information about the availability of financial assistance without charge during the registration process for each patient or upon request at any other time.
- D. The hospital will post information regarding the availability of financial assistance, and this policy, in an easily accessible location on the hospital's web site.
- E. The hospital will provide prominently placed information on all billing notices about the availability of financial assistance.
- F. The hospital will take other actions that hospital management deems appropriate to notify

and inform members of the community about the availability of financial assistance.

2. Procedures for Evaluating Applications:

- A. All self-pay accounts will be screened for potential Medicaid eligibility as well as coverage by other sources, including governmental programs. During this screening process an "FA" will be completed if it is determined that the patient does not appear to qualify for coverage under any program.
- B. The "FA" will be sent to the Business Office for final determination by the Financial Counselor or Business Office Manager.
- C. If the Financial Counselor determines through the application and documented support that the patient qualifies for financial assistance, she/he will give the completed and approved "FA" to the BOM for approval authorization, prior to write *off*.
- D. The following documents will be required to process the application: copies of current monthly expenses/bills, copies of the previous year's income tax return, current copy of employers check stub, proof of any other income, copies of all bank statements for prior 3 months, and copies of all other medical bills. The hospital has the option to pull a credit report to verify information and determine if there are credit cards with available credit that the balance, or portion thereof, could be charged to the credit card. Where patient/guarantor indicates no income, no bank account or does not file taxes, a credit report is required and must be reviewed to determine if there is conflicting information that indicates income. However, if the patient is covered by Medicaid or other similar State or Federal programs (such as Family Planning) a credit report would not be required since income verification has already been validated in order for the patient to be covered under such program. Unless the patient can explain why the credit report reflects conflicting information such as open lines of credit that are current, mortgage loans that are current, credit cards that are current (any one or combination), or credit scores above 600, the financial assistance application may be denied. Acceptable explanations such as recent loss of employment must be supported through documentation such as termination letter or a letter from prior employer stating that the patient/guarantor is no longer employed as of (date). Low credit scores (below 350) will be indication of support for statements such as 'do not file taxes or have no bank account'. Where the patient/guarantor indicates they do not file federal tax returns, the hospital will request that the patient/guarantor complete IRS form 4506-T (Request for Transcript of Tax Return). The patient/guarantor should complete lines 1-5 after the hospital has completed lines 6-9. Hospital will complete line 6 by entering '1040', will check boxes 6(a) and box 7. In box 9, hospital will enter prior year and prior 3 years. (Exhibit F-example and a blank form).
- E. The Financial Counselor will contact any vendor who may be working the account as soon as practicable, to stop all collection efforts on the account.
- F. If the "FA" is incomplete it will be the responsibility of the Financial Counselor to contact the patient via mail or phone to obtain the required information.
- G. Applications that remain incomplete after 45 days may result in denial of application.
- H. The application may be reopened and reconsidered once the required information is received.

- I. The Business Office Manager (or Assistant BOM) is responsible for reviewing every application to make sure required documents are attached, prior to submitting to CFO or CEO for review and approval. All fields on the application must be completed properly. Drawing lines through fields such as income is not appropriate. If the income is zero, zeros must be entered.
- J. Medicaid patients who receive covered services that meet Medicare medical necessity, but have exhausted state benefit limits (IE limited IP days or limited annual ER visits, for example), will not be required to provide any supporting documents providing verification of Medicaid coverage for the service dates is completed.

3. FACTOR TO BE CONSIDERED FOR FINANCIAL ASSISTANCE DETERMINATION

- A. The following factors are to be considered in determining the eligibility of the patient for financial assistance:
 1. Gross Income
 2. Family Size
 3. Employment status and future earning capacity
 4. Other financial resources
 5. Other financial obligations
 6. The amount and frequency of hospital and other medical bills
- B. The income guidelines necessary to determine the eligibility for financial assistance as a financially indigent person and the minimum discounts to be applied to eligible charges are attached on *Exhibit "D"*. The current Alaska Federal Poverty Guidelines are attached as *Exhibit E* and they include the definition of the following:
 1. Family
 2. Income

4. FAILURE TO PROVIDE APPROPRIATE INFORMATION

Failure to provide information necessary to complete a financial assessment within 45 days of the request may result in a negative determination. The account may be reconsidered upon receipt of the required information, providing the information is received within 240 days from the first patient billing date.

5. TIME FRAME FOR ELIGIBILITY DETERMINATION

A determination of eligibility will be made by the Business Office within 30 working days after the receipt of all information necessary to make a determination.

Once the eligibility determination has been made, the results will be documented in the comments section on the patient's account and the completed and approved "FA" will be filed attached to the adjustment sheet and maintained for audit purposes. The CEO, CFO, BOM will signify their review

and approval of the write-off by signing the bottom of the Charity Care/Financial Assistance Program Application form. The signature requirements will be based on the CHS financial policy for approving adjustments.

7. PROCESSING PROCEDURES:

- A. Once approved for financial assistance, the account will be moved to the appropriate financial class until the adjustment is processed and posted/credited to the account. After the adjustment is posted, if there is a remaining balance due from the patient, the financial class will be changed to self-pay.
- B. Once an account has been written off to bad debt per the Hospital's Bad Debt Policy, and at least 240 days have elapsed since the hospital mailed the first billing statement for the care involved, the care involved will no longer be eligible for financial assistance.
1. C. In the event of the patients inability to pay the remaining balance due from the patient see the Collection Cycle Policy which is available at www.matsuregional.com, on the "Community" tab.

8. REPORTING OF FINANCIAL ASSISTANCE

Information regarding the amount of financial assistance provided by the hospital, based on the hospital's fiscal year, shall be aggregated and included in the annual report filed with the Mat-Su Valley Medical Center, LLC Board of Directors. These reports also will include information concerning the provision of government sponsored indigent health care and other borough benefits.

**Exhibit A
FINANCIAL ASSISTANCE POLICY**

This hospital will provide financial assistance to persons who are unable to pay for their care.

In order to be eligible for assistance, you must:

- **Have no other source of payment such as insurance, or savings; or have hospital bills beyond your financial resources; and**
- **Complete an application and provide information required by the hospital, including proof of income and financial resources.**

Forms and information about applying for financial assistance are available upon request, or on hospitals web page at www.matsuregional.com, on the "Community" tab.

Please complete the Financial Assistance Application and return the completed form to: **Pat Allen, Financial Counselor, Mat-Su Regional Medical Center**, or the completed form may be mailed to the following address:

**MatSu Regional Medical Center
P O Box 1687
Palmer, Alaska 99645
Attention: Pat, Financial Counselor (907) 861-6579**

Our FA application is provided in two languages, English and Russian, available at www.matsuregional.com, on the "Community" tab.

Exhibit B

An "Availability of Financial Assistance" sign will be provided in Russian.

ПРАВИЛА ПОЛУЧЕНИЯ БЕСПЛАТНОГО МЕДИЦИНСКОГО ОБСЛУЖИВАНИЯ

Данная больница оказывает медицинские услуги пациентам, которые не могут заплатить за свое лечение.

Для получения права на бесплатное медицинское обслуживание Вам необходимо соответствовать следующим критериям:

- **не иметь дополнительных источников оплаты услуг, например, страховки, правительственных пособий или сбережений; либо**
- **иметь больничные счета на сумму, превышающую объем имеющихся денежных средств; а также**
- **предоставить документы, подтверждающие размер и источник дохода; и**
- **заполнить заявление с указанием всей необходимой для больницы информации.**

Бланк заявления на оказание бесплатного медицинского обслуживания, а также любая дополнительная информация предоставляются по запросу.

PATIENT NAME:

DATE: _____

[patient label]

Mat-Su Regional Medical Center

Exhibit C

Financial Assistance Program Application-English

Patient Account Number _____

Date of Application _____

PATIENT INFORMATION

PARENT/GUARANTOR/SPOUSE

Name _____

Name _____

Address _____

Address _____

City _____

City _____

State/Zip _____

State/Zip _____

Employer _____

Employer _____

Address _____

Address _____

City _____

City _____

State/Zip _____

State/Zip _____

Work Phone _____

Work Phone _____

Length of Employment _____

Length of Employment _____

Supervisor _____

Supervisor _____

RESOURCES

Checking: Yes__ No__

Vehicle 1: Yr____ Make____ Model____

Savings: yes__ no__

Vehicle 2: Yr____ Make____ Model____

Cash on hand: \$._____

Vehicle 3: Yr____ Make____ Model____

Mat-Su Regional Medical Center

Exhibit C (continued) Financial Assistance Program Application

INCOME

Patient/Guarantor Wages (monthly)	\$ _____	Spouse/2 nd parent Wages (monthly)	\$ _____
Other Income Child Support	\$ _____	Other Income Child Support	\$ _____
VA Benefits	\$ _____	VA Benefits	\$ _____
Worker's Comp	\$ _____	Workers Comp	\$ _____
SSI	\$ _____	SSI	\$ _____
Other	\$ _____	Other	\$ _____

LIVING ARRANGEMENTS

Rent _____ Own _____ Other _____

Landlord/Mortgage Holder _____

Phone number _____ Monthly Payments \$ _____

REQUIRED DOCUMENTS

The following documents must be attached to process your application for Financial Assistance:

Proof of Income: Prior year income tax return, last 4 pay check stubs, letter from employer, Social Security, etc. Last 3 months bank statements. Other documents as requested.

Proof of Expenses: Copy of mortgage payment or rental agreement, copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones). Other documents as requested.

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

The Hospital reserves the right to pull a copy of your credit report.

Signature of Applicant _____

Hospital Representative Completing Application: _____

The signatures are an indication of your review of the application and supporting documentation and that you find the information to meet policy requirements.

Approval/Authorization of Charity Write-Off Amount Approved \$ _____

BOM _____

CEO _____

CFO _____

Форма заявления на предоставление финансовой помощи
Региональный медицинский центр Mat-Su
Заявление на участие в Программе благотворительной поддержки/финансовой помощи

Стр. 1 из 2

Учетный номер пациента: _____

Дата обращения: _____

ИНФОРМАЦИЯ О ПАЦИЕНТЕ

РОДИТЕЛЬ/ПОРУЧИТЕЛЬ/СУПРУГ(А)

Имя и фамилия _____

Имя и фамилия _____

Адрес _____

Адрес _____

Город _____

Город _____

Штат/индекс _____

Штат/индекс _____

Номер социального обеспечения _____

Номер социального обеспечения _____

Работодатель _____

Работодатель _____

Адрес _____

Адрес _____

Город _____

Город _____

Штат/индекс _____

Штат/индекс _____

Служебный телефон _____

Служебный телефон _____

Стаж работы _____

Стаж работы _____

Руководитель _____

Руководитель _____

Ресурсы

Чековый счет: да ___ Автомобили 1 Год _____ Марка _____ Модель _____

Сберегательный счет: да ___ Автомобили 1 Год _____ Марка _____ Модель _____

Автомобили 1 Год _____ Марка _____ Модель _____

Наличные средства \$ _____

ДОХОД

Пациент/поручитель
Заробная плата (в месяц): _____

Супруг(а)/второй родитель:
Заробная плата (в месяц): _____

Иной доход: Алименты \$ _____

Иной доход: Алименты \$ _____

Пособие ветеранам: \$ _____

Пособие ветеранам: \$ _____

Компенсация за вред,
причиненный
здоровью работника: \$ _____

Компенсация за вред,
причиненный
здоровью работника: \$ _____

Дополнительная
социальная помощь (SSI): \$ _____

Дополнительная
социальная помощь (SSI): \$ _____

Другое: \$ _____

Другое: \$ _____

ЖИЛЬЕ

Аренда _____ Собственное _____ Другое (поясните) _____

Арендодатель/залогодержатель: _____

Номер телефона _____ Ежемесячная плата \$ _____

НЕОБХОДИМЫЕ ДОКУМЕНТЫ

К вашему заявлению на получение благотворительной поддержки/финансовой помощи необходимо приложить следующие документы:

Подтверждение дохода: декларация по подоходному налогу за прошлый год, корешки последних 4 чеков на выплату заработной платы, письмо от работодателя, органа социального обеспечения и т. д., выписки по банковскому счету за последние 3 месяца. Другие документы по требованию.

Подтверждение расходов: копия договора залога или аренды, копии всех ежемесячных счетов (включая кредитные карты, банковские займы, займы на приобретение автомобиля, страховые платежи, счета за коммунальные услуги, стационарный и мобильный телефон). Другие документы по требованию.

Информация, изложенная в настоящем заявлении, подлежит проверке сотрудниками больницы и была предоставлена с целью определить мою способность погасить задолженность. Я понимаю, что в случае указания мною неверной информации больница откажет мне в предоставлении какой-либо финансовой помощи.

Больница оставляет за собой право получить копию вашей кредитной истории.

Подпись заявителя _____

Сотрудник больницы, оформивший заявление: _____

Подписи указывают на то, что вы рассмотрели заявление и сопроводительную документацию и находите информацию соответствующей установленным правилам.

Одобрение/разрешение на предоставление благотворительной поддержки _____ Одобренная сумма \$ _____

Руководитель подразделения _____ Генеральный директор _____

Финансовый директор _____

Exhibit D
Income Guidelines for Determining % of Discount
(For Financially Indigent Patients)

Based on Current Year Federal Poverty Income Guidelines

% of Poverty Income	Discount from charges
Equal to or Below Poverty	100%
100-150%	100%
151-200%	75%
201-300%	50%
301-400%	25%

Exhibit E

Poverty Income Guidelines for 2015



FINANCIAL MEANS PROGRAM

2018 ALASKA FEDERAL POVERTY GUIDELINE
Effective January 13, 2018

INCOME MUST FIT WITHIN THE ALASKA FEDERAL POVERTY GUIDELINES BELOW TO QUALIFY

HOUSEHOLD	INCOME PER MONTH			
	100%	200%	300%	400%
1	\$1,265	\$2,530	\$3,795	\$5,060
2	\$1,715	\$3,430	\$5,145	\$6,860
3	\$2,165	\$4,330	\$6,495	\$8,660
4	\$2,615	\$5,230	\$7,845	\$10,460
5	\$3,065	\$6,130	\$9,195	\$12,260
6	\$3,515	\$7,030	\$10,545	\$14,060
7	\$3,965	\$7,930	\$11,895	\$15,860
8	\$4,415	\$8,830	\$13,245	\$17,660
FOR EACH ADDITIONAL PERSON ADD	\$450	\$900	\$1,350	\$1,800
DISCOUNT	100%	80%	60%	40%

Incomplete applications will not be considered for the Financial Means Program.

EXHIBIT F
 (Attach IRS Form 4506-T blank form and example of completed form)

Form **4506-T**
 (Rev. September 2015)
 Department of the Treasury
 Internal Revenue Service

Request for Transcript of Tax Return

- ▶ Do not sign this form unless all applicable lines have been completed.
- ▶ Request may be rejected if the form is incomplete or illegible.
- ▶ For more information about Form 4506-T, visit www.irs.gov/form4506t.

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946. If you need a copy of your return, use Form 4506, Request for Copy of Tax Return. There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)
2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number or individual taxpayer identification number if joint tax return
3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)	
4 Previous address shown on the last return filed if different from line 3 (see instructions)	
5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.	

Caution: If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶

- a **Return Transcript**, which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days
- b **Account Transcript**, which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days
- c **Record of Account**, which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days

7 **Verification of Nonfiling**, which is proof from the IRS that you did not file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

/	/	/	/
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Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** For transcripts being sent to a third party, this form must be received within 120 days of the signature date.

Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T. See instructions.

Signature (see instructions)	Date	Phone number of taxpayer on line 1a or 2a
Title (if line 1a above is a corporation, partnership, estate, or trust)		
Spouse's signature	Date	

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 37667N

Form **4506-T** (Rev. 9-2015)

Request for Transcript of Tax Return

- ▶ Do not sign this form unless all applicable lines have been completed.
- ▶ Request may be rejected if the form is incomplete or illegible.
- ▶ For more information about Form 4506-T, visit www.irs.gov/form4506t.

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946. If you need a copy of your return, use Form 4506, Request for Copy of Tax Return. There is a fee to get a copy of your return.

<p>1a Name shown on tax return. If a joint return, enter the name shown first.</p> <p>Patient A</p>	<p>1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)</p> <p>000-00-0000</p>
<p>2a If a joint return, enter spouse's name shown on tax return.</p>	<p>2b Second social security number or individual taxpayer identification number if joint tax return</p>
<p>3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)</p> <p>Patient A, PO Box, Palmer, AK, 99645</p>	
<p>4 Previous address shown on the last return filed if different from line 3 (see instructions)</p>	
<p>5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.</p>	

Caution: If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 Transcript requested. Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ 1040

a Return Transcript, which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days

b Account Transcript, which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days

c Record of Account, which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days

7 Verification of Nonfiling, which is proof from the IRS that you did not file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days

8 Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript. The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 Year or period requested. Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately. | 12 / 31 / 2015 | 12 / 31 / 2014 | 12 / 31 / 2013 | 12 / 31 / 2012

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** For transcripts being sent to a third party, this form must be received within 120 days of the signature date.

Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T. See instructions.

Phone number of taxpayer on line 1a or 2a

▶ _____ Date

Sign Here ▶ _____
 Title (if line 1a above is a corporation, partnership, estate, or trust)

▶ _____ Date

Spouse's signature