Financial Assistance Application

Santiam Hospital understands that medical bills can be unexpected and may be difficult to pay. In order to assist with this burden Santiam Hospital offers financial assistance to our patients that meet certain income requirements. Based on those requirements an individual or family may qualify for a reduction in the cost of services partially or in full, even if you have health insurance.

What does it cover? Financial Assistance covers services at Santiam Hospital as well as any of our affiliated clinics for medically necessary services based on an individual's eligibility. Financial assistance may not cover any additional costs incurred or provided by other organizations.

How do I apply? To apply for financial assistance complete and return the enclosed form by mail to Santiam Hospital Financial Counselor, Po Box 577 Stayton, OR 97383, by fax to 503-769-3472 or by email to patientaccounts@santiamhospital.org. If you have questions or need assistance in filling out this application, please call our financial assistance specialist at 503-769-4572.

What information is needed to apply?

- The enclosed application form (signed and dated)
- Proof of income
- Copy of recent tax return
- Complete and current bank statement
- Include a letter explaining your current situation and additional need for assistance.

When will I know the outcome of my application? You will receive a determination letter in the mail within 21 days after receiving your completed application. If additional information or documentation is required to process the financial assistance application, you will be informed of those requirements.

Please submit your application promptly.

You will continue to receive bills until we receive your information and an eligibility determination has been made.

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Charity Care/Financial Assistance Application Form – confidential

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION

Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*

Has the patient applied for Medicaid? □ **Yes** □ **No**

Does the patient receive state public services such as TANF, Basic Food, or WIC? □ **Yes** □ **No**

Is the patient currently homeless? □ **Yes** □ **No**

Is the patient's medical care need related to a car accident or work injury? □ **Yes** □ **No**

Do you have a current primary care physician? □ **Yes** □ **No** If yes, who? _____

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 21 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION

Patient first name	Patient middle name		Patient last name
□ Male □ Female □ Other (may specify _____)	Birth Date		Patient Social Security Number (optional)
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional)
Mailing Address _____ _____ City State Zip Code			Main contact number(s) ( ) _____ ( ) _____ Email Address: _____

Employment status of person responsible for paying bill

□ **Employed** (date of hire: _____) □ **Unemployed** (how long unemployed:_____)

□ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

FAMILY SIZE _____ *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (*please explain_____)*

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INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application.*

You must provide information on your family's income. Income verification is required to determine financial assistance. <u>All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.</u>

- Current pay stubs (*3 months*); AND
- Last year's income tax return, including schedules if applicable;
- Written, signed statements from employers or others;
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

EXPENSE INFORMATION

(This section is optional and may be used to determine eligibility for other assistance programs)

<u>Monthly Household Expenses:</u>

Rent/mortgage $_____ Medical expenses $_____

Insurance Premiums $_____ Utilities $_____

Other Debt/Expenses $_____ (*child support, loans, medications, other*)

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that Santiam Hospital & Clinics may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

_____ _____

Signature of Person Applying Date