



## Charity Care/Financial Assistance Application Form - confidential

Medical record number:

Valued patient,

Salem Health is committed to providing medical care to those patients who may not have sufficient financial resources available. If you qualify for financial assistance, a portion of your account(s), up to 100% may be forgiven. **This program only covers the medically necessary care provided at Salem Health Hospitals & Clinics. It does not cover any elective procedures, prescriptions, professional or private practice physician fees.**

An application for financial assistance is required for Salem Health to make any financial adjustment to your account(s) balance. Please fill out the enclosed form in its entirety and attach the required documentation, and return to Salem Health.

You will receive a determination letter or request for additional documents letter in the mail within 21 days after we receive your application. **Any other potential sources of payment, such as state medical insurance, health share co-op/cost sharing, liability insurance, workman's comp etc.. Must be exhausted prior to adjusting your account(s).**

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

Should you have any questions, please contact the Financial Assistance Team at (503) 562-4357.

- You may visit our office at 550 Hawthorne AVE SE Salem, OR 97301
- You may fax the completed application and documentation to (503) 814-1998.
- **or** to mail the application, use the PO Box listed below.

Sincerely,

*Financial Assistance Team*

Salem Health and West Valley Hospital

PO Box 14001

Salem, OR 97309-5014

[financial.counselors@salemhealth.org](mailto:financial.counselors@salemhealth.org)



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### **In order for your application to be processed, you must provide:**

1. Current year federal tax filing, we need all pages and schedules. If you own a business please include current year business/corporation taxes. Please do not send hand written taxes, W-2's, or state taxes, as we cannot accept these documents.

**-OR-**

2. If you did not file a current year tax return, you will need to get a non-filing verification letter from the IRS. You may call the IRS at 1-800-829-1040 to request the letter or visit your local IRS office to request that letter.

### **If you have income from any of the following, please attach copies to your application.**

3. Most recent three (3) months wage stubs from your employer. Do not send direct deposit information or bank statements as we need to see the gross pay (before taxes and deductions are taken out).
4. Current year Social Security Administration award letter, please do not send bank statements.
5. Current year pension benefit award letter, please do not send bank statements.
6. Veterans Affairs award letter, please do not send bank statements.
7. Annuity award letter, please do not send bank statements.
8. Unemployment benefits letter, please do not send bank statements.
9. Child support award letter, please do not send bank statements.
10. Alimony award letter or court documents.
11. Student financial aid award letter.
12. Short term disability benefits award letter, please do not send bank statements.
13. Long term disability benefits award letter, please do not send bank statement.

If your household does not have any types of income listed above, please contact our office at 503-562-4357(option #3) to see if you may be eligible for the Oregon Health Plan and we can assist you in applying for the Oregon Health Plan.



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*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? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <i>If Yes, list preferred language:</i>
Has the patient applied for Medicaid? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Does the patient receive state public services such as TANF, Basic Food, or WIC? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Is the patient currently homeless? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Is the patient's medical care need related to a car accident or work injury? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>

### 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
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (may specify _____)	Birth Date	Patient Social Security Number (optional)
Person Responsible for Paying Bill	Relationship to Patient	Birth Date
Mailing Address _____ _____ _____		Social Security Number (optional)
City	State	Zip Code
Main contact number(s) ( ) _____ ( ) _____		Email Address: _____
Employment status of person responsible for paying bill <input type="checkbox"/> <b>Employed</b> (date of hire: _____) <input type="checkbox"/> <b>Unemployed</b> (how long unemployed: _____) <input type="checkbox"/> <b>Self-Employed</b> <input type="checkbox"/> <b>Student</b> <input type="checkbox"/> <b>Disabled</b> <input type="checkbox"/> <b>Retired</b> <input type="checkbox"/> <b>Other</b> (_____)		

### 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



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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 \_\_\_\_\_)

#### 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. **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.**

**Examples of proof of income include:**

- A "W-2" withholding statement; or
- Current pay stubs (3 months); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- 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

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

Rent/mortgage	\$ _____	Medical expenses	\$ _____
Insurance Premiums	\$ _____	Utilities	\$ _____
Other Debt/Expenses	\$ _____ (child support, loans, medications, other)		

#### ASSET INFORMATION

Current checking account balance  
\$ \_\_\_\_\_

Current savings account balance  
\$ \_\_\_\_\_

Does your family have these other assets?  
**Please check all that apply**

Stocks    Bonds    401K    Health Savings Account(s)    Trust(s)

Property (excluding primary residence)    Own a business

#### 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 Salem Hospital 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