## 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 fax the completed application and documentation to (503) 814-1998.
- You may e-mail the application and documents to financial.counselors@salemhealth.org
- Or to mail the application, use the PO Box information listed below.

Sincerely,
*Financial Assistance Team*
Salem Health and West Valley Hospital
PO Box 14001
Salem, OR 97309-5014
financial.counselors@salemhealth.org

# Charity Care/Financial Assistance Application Form - confidential

**<u>In order for your application to be processed, you must provide:</u>**

1. Current year <u>federal</u> 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 <u>non-filing verification letter</u> 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.

# 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**

## 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<br>□ 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 |

# Charity Care/Financial Assistance Application Form - confidential

**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<br>$______________________________<br>Current savings account balance<br>$______________________________ | Does your family have these other assets?<br>**Please check all that apply**<br>□ Stocks □ Bonds □ 401K □ Health Savings Account(s) □ Trust(s)<br>□ 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