Adventist Health Portland a member of OHSU HEALTH

How to apply for financial assistance

Instructions for filling out your application

By law, all hospitals must provide financial assistance to people and families who meet certain requirements. You may be able to get free care or pay less for certain services based on your family size and income, even if you have health insurance. To view our financial assistance policy, please go to **adventisthealth.org/portland/patient-resources/patient-financial-services/financial-assistance**

What is covered by financial assistance

- Not all services qualify so you will need to make sure that the service is covered before you get it. For a list of services **we do NOT cover,** see our financial assistance policy at **adventisthealth.org/portland/patient-resources/patient-financial-services/financial-assistance**
- Please note that if you are approved for financial assistance, it does NOT guarantee that you will get services.
- If you could qualify for Medicaid or other programs, we encourage you to apply for these as they may have more benefits.

Steps to complete the application form

❶ Fill out information about you and your family.
- You do **NOT** need to provide your social security number.
- We define a household as a single person, married couple or registered domestic partner (even if they are not on your tax return), plus any dependents that you claim on your tax return. A child under 18 is usually a dependent. Examples of households:
  - Legally married couples (or domestic partners) who live together, along with their dependent children under 18 years, and anybody else who lives in or outside the household that the couple claims on their taxes
  - Unmarried couples with one or more children in common, if the child is the patient
  - Sponsored non-citizen, their sponsor, and sponsor's family

❷ Fill out information about your household's gross income (income before taxes and deductions).

❸ Declare and provide proof of assets to help us see if you are eligible for Medicaid programs.

❹ Attach all other information that we have asked for.

❺ Sign and date the financial assistance form.

For help filling out the application, call **503-494-8551**, Monday-Friday, 9 a.m-4:30 p.m.

Documents to include with the form

Please **send the most current copies** of all documents below that apply to you. We will **NOT** be able to return original documents

- ☐ **Proof of residency**. Provide one of the following: utility bill in your name, rental agreement, mortgage statement for your residence, copy of your driver's license or identification card. We may ask for additional proof of residency. *You must be a resident of the state of Oregon or bordering county in the state of Washington (Benton, Clark, Columbia, Cowlitz, Klickitat, Lewis, Pacific, Skamania, Wahkiakum, Walla Walla, and Yakima) with no plans to move out of the area.*
- ☐ **Paycheck stubs** for the last 3 full calendar months. If you do not have your paystubs, you may give us a letter from your employer that lists your gross income for the last 3 full calendar months. *Income is counted in the month it was received (pay date) and not the month it was earned.*
- ☐ **Income tax returns** for the most recent year filed, including any schedules (such as schedule C for self-employment income).
- ☐ **Social Security, Veterans, Pension Award Letter,** or the equivalent
- ☐ **Claims determination** from the State Employment Division
- ☐ **Child support** and/or **spousal support** statement
- ☐ **Self-Employment Income Worksheet** or **Profit and Loss** statement for the last 3 full calendar months
- ☐ Verification documents for **any other income source** listed on your application, including income from interest or dividends, or any other recurring source of income
- ☐ **Bank/credit union statements**; checking and savings accounts
- ☐ **Cash deposit (CD), stocks, bonds, or investment account statements**

Turn in the form

- We will let you know if you qualify for financial assistance within **3 weeks** after we get your completed application and required documents.
- You may still receive bills while application is within review.

Mail: Oregon Health & Science University Patient Financial Services, RPB07 3181 SW Sam Jackson Park Road Portland, OR 97239-3098 **Fax:** 503-418-2377 **Email:** sfr@ohsu.edu	**To deliver in person:** Please call 503-494-8551 to determine location closest to you

Financial Assistance Application Form

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 houseless? □ **Yes** □ **No**

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

Which facility is the patient seeking financial assistance? □ **Adventist Health Portland** □ **Hillsboro Medical Center** □ **OHSU**

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 (include physical address if different) _____ _____ 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 household/family members that you are financially responsible for, including yourself. Please see the instructions for definitions and examples of household.

FAMILY SIZE_____ *Attach additional page if needed*

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

All adult family members' earned and unearned income must be disclosed. Please provide unearned income for anyone in the household who is under 18. 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 must disclose their income. Please provide proof for every identified source of income. Please see the cover sheet for a complete list of income requirements. Examples of proof of income include:</u>

- Current pay stubs (3 months); and
- Last year's income tax return, including schedules, if applicable; and
- Written, signed statements, from employers or others; and
- Approval/denial of eligibility for Medicaid and/or state funded medical assistance; and
- Approval/denial of eligibility for unemployment compensation
- Statements from financial institutions

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

EXPENSE INFORMATION

Optional. May be used in some situations to get a more complete picture of your financial situation.

<u>Monthly Household Expenses:</u>

Rent/mortgage $_____ Medical expenses $_____

Insurance Premiums $_____ Utilities $_____

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

ASSET INFORMATION

This information will be used to determine eligibility for certain Medicaid programs.
It is not used for financial assistance determinations

Current checking account balance
$_____

Current savings account balance
$_____

Does your family have these other assets?
<u>Please check all that apply</u>

□ Stocks □ Bonds □ 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 OHSU Health 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