

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



- ➊ 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
- ➋ Fill out information about your household's gross income (income before taxes and deductions).
- ➌ Declare and provide proof of assets to help us see if you are eligible for Medicaid programs.
- ➍ Attach all other information that we have asked for.
- ➎ 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.

<p>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</p>	<p>To deliver in person: Please call 503-494-8551 to determine location closest to you</p>
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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	
<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	Social Security Number (optional)	
Mailing Address (include physical address if different)				Main contact number(s)	
_____				() _____	
_____				() _____	
City State Zip Code				Email Address:	
Employment status of person responsible for paying bill _____					
<input type="checkbox"/> Employed (date of hire: _____) <input type="checkbox"/> Unemployed (how long unemployed: _____) <input type="checkbox"/> Self-Employed <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> 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*) _____



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 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:

- 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.

Monthly Household Expenses:

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

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 \$ _____	Does your family have these other assets? Please check all that apply <input type="checkbox"/> Stocks <input type="checkbox"/> Bonds <input type="checkbox"/> Health Savings Account(s) <input type="checkbox"/> Trust(s) <input type="checkbox"/> Property (excluding primary residence) <input type="checkbox"/> Own a business
Current savings account balance \$ _____	

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