PROVIDENCE
Health & Services

# Request for Charity Care/Financial Assistance

Dear Patient and Family:

In keeping with its mission and core values, we are committed to providing health care for people regardless of their ability to pay.

**Our Charity Care/Financial Assistance:**
Medical bills may be difficult to pay. Patients who are unable to pay for all or part of their health care services, may apply for financial assistance by completing and returning this form. Patients and families who meet certain income requirements may qualify for free care or reduced-price care based on their family size and income, even if you have health insurance.

To view our financial assistance policy and sliding scale guidelines, please go to residing State website:
https://www2.providence.org/obp/states/OR/financial-assistance.html

**What does financial assistance cover?** Financial assistance covers medically necessary services provided by one of our ministries, depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

**If you have questions or need help completing this application:** Our financial assistance policies, information about the programs, and application materials are available on our website or via phone. You may obtain help for any reason, including disability and language assistance. Here's how to contact us:
https://www2.providence.org/obp/states/OR/financial-assistance.html
Customer Service Representatives at:
503-215-3030 or 866-747-2455 Monday - Friday 8:00am to 8:00pm

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

- □ **Information about your family**
  Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- □ **Information about your family's gross monthly income** (income before taxes and deductions)
- □ **Declare assets** (as listed on financial assistance application form)
- □ **Attach additional information if needed**
- □ **Sign and date financial assistance form**

****Income Source Verification Required****
**Please submit with your application copies of the following documents:**

- 3 months of employment pay stubs
- Recent filed tax return for all family members
- Please provide proof of any other income source as listed on financial assistance application form

**Note**: **You do not have to provide a Social Security number to apply for financial assistance**. If you provide us with your Social Security number it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

**Mail completed application with all documentation to** (be sure to keep a copy for yourself)**:**
https://www2.providence.org/obp/states/OR/financial-assistance.html
PH&S Regional Business Office, P.O. Box 3299, Portland, OR 97208-3395

**To submit your completed application in person**: Take to your nearest Hospital Cashier Office

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income.

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

**We want to help. Please submit your application promptly!**
**You may receive bills until we receive your information.**

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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** *May be required to apply before being considered for financial assistance*

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 14 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 | | Social Security Number (optional*)<br>**optional, but needed for more generous assistance above state law requirements* |
| Person Responsible for Paying Bill | Relationship to Patient | Birth Date | Social Security Number (optional*)<br>**optional, but needed for more generous assistance above state law requirements* |
| Mailing Address<br>_____<br>_____<br>City State Zip Code | | | Main contact number(s)<br>( ) _____<br>( ) _____<br>Email Address:<br>_____ |

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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# Charity Care/Financial Assistance Application Form – confidential

## 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>**

**<u>Examples of proof of income include:</u>**

- 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.*

<u>Monthly Household Expenses:</u>

Rent/mortgage $_____

Insurance Premiums $_____

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

Medical expenses $_____

Utilities $_____

## ASSET INFORMATION

*This information may be used if your income is above 200% of the Federal Poverty Guidelines.*

Current checking account balance
$_____

Current savings account balance
$_____

Does your family have these other assets?
**<u>Please check all that apply</u>**
□ 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, seasonal or temporary income, or personal loss.

## PATIENT AGREEMENT

I understand that Providence Health & Services 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 information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.

_____ _____

Signature of Person Applying Date