St. Charles HEALTH SYSTEM

Charity Care/Financial Assistance Application Form – confidential

- Please return completed Applications to a financial counselor at any St. Charles hospital, mail to St. Charles Financial Assistance department, PO Box 6095 Bend, OR 97708, email to financialassistance@stcharleshealthcare.org, or Fax to 541-706-6707.

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 been approved for Medicaid? □ **Yes** □ **No** Has the patient applied for COBRA? □ **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**
Is there anyone you give us permission to speak with on your behalf? *If Yes, list names:*

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 _____ _____ City State Zip Code			Main contact number(s) ( ) _____ ( ) _____ Email Address: _____

FAMILY INFORMATION

Family is defined as a single individual, spouses, domestic partners, parents and their children under 18 years of age, who are living together, and other individuals for whom the individual, spouse, domestic partner or parent is financially responsible.

FAMILY SIZE _____ *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient/Applicant	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):	List name of Medical Insurance Company
		Self			

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INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application.*

***Employment status of person responsible for paying bill**:*

□ Employed (date of hire: _____) □ Unemployed (date of unemployment: _____)
□ Self-Employed □ Student □ Disabled □ Retired □ Other

Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. Please provide proof for every identified source of income. **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

Examples of proof of income include (*St Charles does NOT accept bank statements as proof of income):*

- 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 or cannot provide documentation, please attach an additional page with an explanation.

ASSET INFORMATION

*This section is **optional** and may be used to determine eligibility for specialty programs such as catastrophic coverage*

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 St. Charles Health System 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