

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

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 \$_____	Does your family have these other assets? Please check all that apply <input type="checkbox"/> Stocks <input type="checkbox"/> Bonds <input type="checkbox"/> 401K <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 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