Applying for Financial Assistance

Inside you will find the application form to process your request for financial assistance for your account(s) with Columbia Memorial Hospital.

For financial assistance consideration, all of the following documents must be signed and returned to the Business Office within 14 working days:

- Completed Financial Assistance Application Form (inside this brochure)
- Copies of your most recent Federal and State income tax returns
- Two months' payroll stubs for all sources of income
- Last two months of bank statements
- Social Security benefit letter
- Oregon Health Plan (OHP) application denial letter

After receiving your complete application form and other documents, the hospital will consider and verify your application information. You will be notified of the decision within 30 days.

If you have any questions, please give us a call at **503-338-7530** or send us an email **FinancialCounselor@columbiamemorial.org**.

Return by mail to:
Columbia Memorial Hospital
Financial Counseling
2111 Exchange St.
Astoria, OR 97103

Drop off at:
CMH Health & Wellness Pavilion Lobby
2265 Exchange St.
Astoria, OR 97103

Contact us with questions:
503-338-7530
FinancialCounselor@columbiamemorial.org

COLUMBIA MEMORIAL HOSPITAL

EXCELLENCE IN PERSON CENTERED CARE
PLANETREE CERTIFIED

For more information on services, visit www.columbiamemorial.org.

M-BR02 (REV1/2020) Q:Form

COLUMBIA MEMORIAL HOSPITAL'S

Application for Financial Assistance

COLUMBIA MEMORIAL HOSPITAL

FINANCIAL ASSISTANCE APPLICATION

Please answer the questions below as completely as possible. All information will be kept confidential. If you have any questions, please call (503) 338-7530 or 1 (800) 962-2407. Monday-Friday 8 a.m. to 5 p.m.

Date Patient's Name Last First M.I. Social Security Number DOB

Patient's Account Number(s) Balance Health Insurance

Mailing Address Telephone How long

Spouse/Parent/Guardian Address Telephone

Names of Adults in Household currently employed SS# Employer Work# How Long

(1)_____

(2)_____

Total # in household _____

List Children in Household

First Name	Last Name	Age

	ADULT HOUSEHOLD INCOME	Person 1	Person 2		MONTHLY EXPENSES	
A	Amount in checking / savings account				Rent/Mortgage	
B	Monthly income, gross (attach verification)				Utilities	
C	Unemployment benefits				Phone	
D	How long employed				Food	
E	Social Security, pensions (attach verification)				Car Payment	
F	Alimony/child support (attach verification)				Health Insurance Premium	
G	Government assistance, food stamps (attach verification)				Home/Auto Insurance Premium	
H	Source and amount of other income (attach verification)				Other Medical Bills	
I	Applied for Medicaid? Yes or No				Other	

Check that you provided:

☐ Previous year's complete Federal tax return ☐ 2 months of recent pay stubs ☐ Bank statements for the last 2 months

I hereby certify the information in the above financial questionnaire is correct and complete to the best of my knowledge. I authorized Columbia Memorial Hospital at their expense to run a credit and or asset report for verification. I agree that the hospital reserves the right to collect The Financial Assistance Award if at a later date a liability settlement, insurance coverage, state programs or government programs coverage becomes available.

X_____ _____

Responsible Person Signature Date