



# GRANDE RONDE HOSPITAL AND CLINICS

PO Box 3290, La Grande, OR 97850

## 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

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 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 last name       |            | Patient Birth Date                                                       |
| Person Responsible for Paying Bill                                                                                                                                                                                                                                                                                                                                                                                          | Relationship to Patient | Birth Date | Social Security Number (optional)                                        |
| Mailing Address<br>_____<br>_____<br>_____                                                                                                                                                                                                                                                                                                                                                                                  |                         |            | Main contact number(s)<br>( ) _____<br>( ) _____<br>Email Address: _____ |
| City                                                                                                                                                                                                                                                                                                                                                                                                                        | State                   | Zip Code   |                                                                          |
| Employment status of person responsible for paying bill<br><input type="checkbox"/> <b>Employed</b> (date of hire: _____) <input type="checkbox"/> <b>Unemployed</b> (how long unemployed: _____)<br><input type="checkbox"/> <b>Self-Employed</b> <input type="checkbox"/> <b>Student</b> <input type="checkbox"/> <b>Disabled</b> <input type="checkbox"/> <b>Retired</b> <input type="checkbox"/> <b>Other</b> ( _____ ) |                         |            |                                                                          |

### FAMILY INFORMATION

Family is defined as: a group of two people or more (one of whom is the head of household) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. Grande Ronde Hospital and Clinics will also accept non-related household members when calculating family size.

**FAMILY SIZE** \_\_\_\_\_

Attach additional page if needed.

| Name | Date of Birth | Relationship to Patient | If 18 years old or older:<br>Employer(s) name or<br>source of income | If 18 years old or older:<br>Total gross monthly<br>income (before taxes): | Also applying for<br>financial<br>assistance? |
|------|---------------|-------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------|
|      |               |                         |                                                                      |                                                                            | Yes / No                                      |
|      |               |                         |                                                                      |                                                                            | Yes / No                                      |
|      |               |                         |                                                                      |                                                                            | Yes / No                                      |
|      |               |                         |                                                                      |                                                                            | Yes / No                                      |

**All household 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 \_\_\_\_\_)

#### 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 household members 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.**

**Examples of proof of income include:**

- Current pay stubs (3 months);
- Last 3 months of all Bank Account Transaction History
- Last year's income tax return, including schedules if applicable;
- Written, signed statements from employers or others; 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

*(This section is optional and may be used to determine eligibility for other assistance programs)*

Monthly Household Expenses:

Rent/mortgage \$ \_\_\_\_\_

Medical expenses \$ \_\_\_\_\_

Insurance Premiums \$ \_\_\_\_\_

Utilities \$ \_\_\_\_\_

Other Debt/Expenses \$ \_\_\_\_\_ (child support, loans, medications, other)

#### ASSET INFORMATION

*(This section is optional and may be used to determine eligibility for other assistance programs)*

Current checking account balance

\$ \_\_\_\_\_

Current savings account balance

\$ \_\_\_\_\_

Brokerage Account(s) Balances (stocks, bonds, mutual funds)

\$ \_\_\_\_\_

Does your family have these other assets?

**Please check all that apply**

☐ 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 Grande Ronde Hospital, Inc. 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



### FINANCIAL ASSISTANCE APPLICATION CHECKLIST

**Please note that your application will not be processed until all the required documentation is received.**

☐ If you are uninsured, please provide a statement explaining why. If you applied for the OREGON HEALTH PLAN and were denied coverage, please provide your denial letter.

☐ Name of Health Insurance Company:

▪ Private Insurance: \_\_\_\_\_

▪ Employee Insurance: \_\_\_\_\_

☐ Educator or Seasonal Employee:

☐ No ☐ Yes, month range I receive checks from  
employer: \_\_\_\_\_

☐ Three months bank account transaction history

☐ Three months of recent paystubs for every working member of your household

☐ Copy of most recent personal State & Federal tax returns, **ALL** pages **ALL** schedules

- **If you do not file taxes, written statement explaining why.**
- **If you are legally required to file taxes, they are required for the FA application to be processed.**

☐ Copy of most recent business State & Federal tax returns, **ALL** pages **ALL** schedules

☐ Copy of unemployment; include a copy of Unemployment payment statements

☐ Copy of Social Security statement for current year

☐ Copy of Alimony court document showing what is received

☐ Copy of Child Support court document showing what is received

☐ Copy of student financial aid (loans, grants etc.) for the current school year

☐ A letter signed and dated from any person who is helping you, i.e. housing, food, money etc.

☐ A letter signed and dated conveying any extenuating circumstances (example: why information is missing). Please provide as much detail as possible.

☐ Other: \_\_\_\_\_

**If you have any questions regarding the completion of this application please contact a Financial Counselor at (541) 963-2845.**