


REQUEST FOR FINANCIAL ASSISTANCE

GUARANTOR INFORMATION	
Name: Date of Birth: Mailing Address: City/State/Zip: Phone:	 <div style="display: inline-block; vertical-align: middle; margin-left: 20px;"> GRANDE RONDE HOSPITAL </div> <p style="font-size: small; margin-top: 20px;">900 Sunset Drive, P O Box 3290, La Grande, OR 97850</p>

	SUPPORTING DOCUMENTATION REQUIREMENTS:
Return completed application to: Grande Ronde Hospital Attention: Financial Assistance Program PO Box 3290 La Grande OR 97850 Please return application by: _____	Required Documentation: Attached you will find a checklist of the documentation required with submission of this application. If the required documents are not submitted, your application will be rejected. <i>All information provided is protected by our privacy guidelines (HIPAA)</i>

Household Information: Please list ALL people living in your household. Children 18 & Under

Household Members <small>(Write on back if need more room)</small>	Age & Date of Birth	Relationship to Guarantor	Name of Current Employment	Length of Employment	Other Source of Income
1.					
2.					
3.					
4.					
5.					
6.					

Household Income

Description	Monthly Amount	Description	Monthly Amount	Description	Balance
Monthly Gross Income		Child Support Received		Bank Checking Account	
Unemployment Benefits		Alimony Received		Bank Savings Account	
Social Security		School Grants & Financial Aide		Business Bank Checking Account (If self-employed)	
Pension, Annuities, IRA		Government Assistance (HUD Housing)		Business Bank Savings Account (If self-employed)	
Food Stamps		Other Source of Income		Business Tax Value (If self-employed)	

Please answer the questions above as completely as possible. All information will be kept confidential. If you have any questions, please call, (541) 963-1400, Monday thru Friday, 8 AM to 5 PM.

Authorization

I hereby certify the information in the above financial questionnaire is correct and complete to the best of my knowledge. I authorize Grande Ronde Hospital to verify the information given; verification may include a Credit Report inquiry.

Responsible Person's Signature: _____ **Date:** _____

HOSPITAL USE BEYOND THIS POINT

Account Number(s): _____ MRN _____ Balance Owning: _____ Account Number(s): _____ Balance Owning: _____ <input type="checkbox"/> SS <input type="checkbox"/> LTR <input type="checkbox"/> DEP <input type="checkbox"/> FPL <input type="checkbox"/> EPIC NOTE <input type="checkbox"/> SCANNED	Approved Date: _____ Family Size: _____ Income: _____ Approved Percentage: _____ Previous FA: _____ PFS Manager: _____ CFO: _____
---	--



Grande Ronde Hospital, Inc.

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 statements of **ALL** bank accounts, personal and business

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 Food Stamp Assistance letter

Copy of Housing Assistance (i.e. HUD)

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

Proof of any other income such as: pensions, annuity etc.

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: _____