GRANDE RONDE HOSPITAL

900 Sunset Drive, PO Box 3290, La Grande, Or 97850

Charity Care/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 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: _____
Employment status of person responsible for paying bill □ **Employed** (date of hire: _____) □ **Unemployed** (how long unemployed:_____) □ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)			

FAMILY INFORMATION

Household means: a single individual; or spouses, domestic partners, or a parent and child under 18 years of age, living together; and other individuals for whom a single individual, spouse, domestic partner or parent is financially responsible.

FAMILY SIZE _____ *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	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):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family 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. <u>All family members 18 years old or older 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.</u>
<u>Examples of proof of income include:</u>

- Current pay stubs (*3 months*);
- Last 3 months Bank Account Statements: Personal and Business;
- Last year's income tax return, W-2 forms, and schedules if applicable;
- Written, signed statements from employers or others;
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance;
- Approval/denial of eligibility for unemployment compensation;
- Financial aid, grant, and school loan documentation

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)

<u>Monthly Household Expenses:</u>

Rent/mortgage $_____
Insurance Premiums $_____
Other Debt/Expenses $_____ (*child support, loans, medications, other*)
Medical expenses $_____
Utilities $_____

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?
<u>Please check all that apply</u>
□ 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. 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

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

☐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.