Application for Financial Assistance

Oregon Anesthesiology Group, PC

OAG offers a program that provides financial assistance for people and families who meet income requirements. You may qualify for free or reduced-price care based on your family size and income, even if you have health insurance.

IMPORTANT NOTE: If you received financial assistance from your hospital or surgeon's office, you do not need to submit an application. Simply send a copy of your financial assistance letter to the address or fax number below. In most cases, OAG will match the terms of your hospital or surgeon's office financial assistance.

We want to help. Please submit your application promptly!
Send your completed application with all documentation by mail or fax to:

Address:
Medac
ATTN: OAG Patient Accounts
150 Bluff Avenue
North Augusta, SC 29841

Fax Number:
ATTN: OAG Patient Accounts
(706) 396-3222

Application Check List

- [x] **Include all of the required documentation regarding income.**

  Our response may be delayed if we receive a partial application.
- [ ] Do not send original documents.
- [ ] Keep a copy of your application.
- [ ] Sign and date the application.
- [ ] Mail or fax your application promptly to the address or fax number listed above.
- [ ] Reminder: You will continue to receive bills until we receive your application.

If you need help completing this application, please contact us at (503) 972-7103.

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

PLEASE NOTE

- We cannot guarantee that all applicants will qualify for financial assistance.
- Once you send in your application, we may ask for additional information or proof of income.
- We will notify you in writing if you qualify for assistance or not. This will happen within **30 calendar days** of receipt of your completed application and documentation.

PATIENT AND APPLICANT INFORMATION

Patient first name:	Patient middle name:	Patient last name:	Patient Birth Date:

Name of Person Responsible for Paying Bill:	Relationship to Patient:	Birth Date:

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

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

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
					Yes / No
					Yes / No

INCOME INFORMATION

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

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 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.

Examples of proof of income include:

- 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.

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know about such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that OAG or OAG's vendor may verify information by reviewing credit information and obtaining information from other sources to determine my eligibility for financial assistance.

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 false, my request for financial assistance may be denied.

_____

Printed Name of Person Applying

_____ _____

Signature of Person Applying Date