



# 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:**

Oregon Anesthesiology Group  
707 SW Washington Street, Suite 700  
Portland, OR 97205

**Fax Number:**

ATTN: OAG Patient Accounts  
(503) 295-2232

## Application Check List

**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:		Main contact number(s):	
		( ) _____	
		( ) _____	
City	State	Zip Code	Email Address:
Employment status of person responsible for paying bill:			
<input type="checkbox"/> <b>Employed</b> (date of hire: _____) <input type="checkbox"/> <b>Unemployed</b> (how long unemployed: _____)			
<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> ( _____ )			
<b>FAMILY INFORMATION</b>			
List family members in your household, including you. “Family” includes people related by birth, marriage, or adoption who live together.			
<b>FAMILY SIZE</b> _____		<i>Attach additional page if needed</i>	
Name	Date of Birth	Relationship to Patient	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.

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Printed Name of Person Applying

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Signature of Person Applying

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Date