WILLAMETTE VALLEY MEDICAL CENTER

Willamette Valley Medical Center
Charity Care/Financial Assistance Application Form

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

Please provide the information requested and mail to the following address:

Financial Assistance Office
PO BOX 290429
Nashville, TN 37229-0429

SCREENING INFORMATION
Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*
Has the patient applied for Medicaid? □ **Yes** □ **No** *May be required to apply before being considered for financial assistance*
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.
- The Financial Assistance Application ***will not*** apply to any amounts due by you for physician services.

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*) **optional, but needed for more generous assistance above state law requirements*
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional*) **optional, but needed for more generous assistance above state law requirements*
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

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>Please provide a copy of the following documents:</u>**
- A "W-2" withholding statement; or
- Current pay stubs (*2 months*);
- Last year's income tax return, including schedules if applicable;
- Government Assistance, Social Security, Workers Compensation, or Unemployment Compensation Determination Letter.

Please also include any of the following that apply to you/ your situation:
- 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

In the event income verification is unavailable, please contact our office for further instructions. Applications without verification are considered incomplete and **WILL NOT BE PROCESSED**.

EXPENSE INFORMATION

We use this information to get a more complete picture of your financial situation.

<u>Monthly Household Expenses:</u>

Rent/mortgage $_____ Medical expenses $_____

Insurance Premiums $_____ Utilities $_____

Other Debt/Expenses $_____ (*child support, loans, medications, other*)

ASSET INFORMATION

This information may be used if your income is above 101% of the Federal Poverty Guidelines.

Current checking account balance
$_____

Current savings account balance
$_____

Does your family have these other assets?
<u>Please check all that apply</u>

□ Stocks □ Bonds □ 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. For assistance in completing this application, please contact the Financial Assistance Office at 800-433-1009 or by fax 866-908-8875 Monday through Friday between the hours of 7:30 and 6:00 pm.

PATIENT AGREEMENT

I understand that *Willamette Valley Medical Center* 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