St. Charles Health System, Inc. wants to provide financial assistance to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance. *For more information visit us at www.stcharleshealthcare.org in the search bar type* ***financial assistance.***

What does financial assistance cover? Financial assistance covers appropriate hospital and clinic services provided by St. Charles depending upon your eligibility. Financial assistance may not cover all health care costs. If you have an account that has been sent to collections, and the first bill was sent to you less than 240 days ago, the account may qualify for the financial assistance program. This program also may cover services provided by other organizations. This assistance will cover St. Charles Medical Group physician charges as well as St. Charles lab charges.

If you have questions or need help completing this application please contact Customer Service: Customer Service (541)706-7750. You may obtain help for any reason, including disability and language assistance.

In order for your application to be processed, you must:

- □ **Provide us information about your family**
  Fill in the number of family members in your household (family generally includes the patient, responsible party, spouse, natural and adopted children under age 18 and live-in partners who together have natural or adopted children under age 18)
- □ **Provide us information about your family's current gross monthly income (income before taxes and deductions)**
- □ **Provide last year's income tax return, including all applicable schedules**
- □ **Complete the "Asset Information" box on the application. If you have assets, provide documentation.**
- □ **Attach additional information if needed**
- □ **Sign and date the form**
- □ If there is additional information you would like us to know, attach this to your application.

Note: **You do not have to provide a Social Security number to apply for financial assistance**. If you provide us with your Social Security numbers it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

Mail or fax completed application with all documentation to: St. Charles Health System, Business Services Office, Attention: Financial Assistance, PO Box 6095, Bend, OR 97708 or Fax: 541-706-6707. Be sure to keep a copy for yourself. **To submit your completed application in person**: Please stop by any St. Charles facility. Hospital sites have financial counselors to assist you.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 21 calendar days of receiving a complete financial assistance application, including documentation of income. *An incomplete application will result in processing and determination delays.* By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

Proof of Income Documentation

This list is a guide of acceptable types of documents that you can turn in as proof of your household income. Please return income documentation for all income earners 18 years of age or older living in your household. The column on the left lists the most common forms of income, and on the right are the corresponding documents to return with your application. It is required that you submit the most recent documents available. The list below is not all-inclusive.

Tax Return (Form 1040/A/EZ, etc.) (Required)... You can obtain a copy of your most recent tax returns and all applicable schedules at no charge by calling the IRS at (800) 829-1040 or ordering it online at http://www.irs.gov/Individuals/Get-Transcript.

Social Security Retirement..... Benefit statement for the current year; copy of last year's IRS-1099. To have a current statement sent to your home, call the **Social Security Administration at 1-800-772-1213**. **OR**

Social Security Disability..... The same documents listed above for Social Security Retirement are acceptable. Use the contact information listed above. **OR**

Supplemental Security Income..... The same documents listed above for Social Security Retirement are acceptable. Use the contact information listed above. **OR**

Veteran's Benefits..... Benefit statement for the current year; last year's tax summary document. **OR**

Pension/Retirement..... Benefit statement for the current year; last year's tax summary document. **OR**

Salary/Wages..... W-2 for last year with the date you started working for that employer; three months consecutive documentation including paystubs; letter on company letterhead; notarized statement from employer. **OR**

Self-employment income..... 1099 form with Schedule C; three months consecutive Profit & Loss statement; three months consecutive check or pay stub/check stub. **OR**

Unemployment..... Unemployment award letter on company letterhead indicating amount and time period covered; copy of most recent unemployment check or check stub. **OR**

Alimony/Child Support..... Court award letter indicating amount and time period covered; Child Support Enforcement Agency letter; letter from attorney stating amount and time period covered; copy of one month's check. **OR**

Rental Income..... Copy of rent check; copy of lease; three months consecutive Profit & Loss statement **OR**

Workers Compensation..... Award letter or benefits statement indicating amount and time period covered; one month's check or check stub. **OR**

Other..... Award letter or benefits statement; copy of check(s); judgement statement; written explanation.

SCREENING INFORMATION

Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*

Has any household member applied for Medicaid/OHP? □ **Yes** □ **No** *May be required to be considered for Financial Assistance*

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.
- We will notify you whether or not you qualify for assistance within 21 calendar days after we receive your completed application and documentation.
- Billing will continue while your application is pending review. This application only applies to visits with a balance due.
- Do not send original documents; they will not be returned to you.
- Please do not staple documents together.

APPLICANT INFORMATION

Legal Last Name(s)	Legal First Name	Legal Middle Name
□ Male □ Female □ Other (may specify)	Birth Date	Social Security Number (optional)
Mailing Address _____ _____ City State Zip Code		Main contact number(s) (H) _____ (C) _____ May we leave a detailed voicemail? Circle: Yes No

Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional)

Employment status of person responsible for paying bill:

□ **Employed** (date of hire - REQUIRED:_____) □ **Unemployed** (how long: _____)

□ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)

Do you have anyone that we can speak to on behalf of your application? □ **Yes** □ **No**

Name	Relationship	Phone Number

FAMILY INFORMATION

List family members in your household, including you. "Family" includes patient, responsible party, spouse, natural or adopted children **under age 18**, and live-in partner if together you have natural or adopted children **under age 18**.

FAMILY SIZE_____ *Attach additional page if needed*

Name (Last, First)	Birth Date	Relationship to Applicant	Employer(s) name or source(s) of income	Total gross monthly income (before taxes):	List name of medical insurance company.
		Self			☐ not insured
					☐ not insured
					☐ not insured
					☐ not insured

FUTURE PROCEDURES

Are you asking for a financial assistance decision <u>before</u> a test or surgery at a St. Charles hospital or clinic?
NOTE: The future service is required to be scheduled and have a physician order in the system to be eligible for pre-determination. Not all services are eligible for review before the visit.

☐ Yes – Fill out the boxes below
☐ No – Continue to "INCOME INFORMATION"

Patient Name		**Date of Birth**	
What service is needed?		Procedure Date	
Physician / Clinic Name		Physician Phone #	
St. Charles Facility	☐Bend ☐Redmond ☐Madras ☐Prineville ☐Clinic (name/location) _____	Physician Fax #	

INCOME INFORMATION

***REMEMBER**: You **must** include proof of income with your application.*

<u>Required Proof of Income:</u>

- Current proof of income (3 recent consecutive months) **– See attached "Proof of Income Documentation";**
- **AND** Last year's income tax return, including schedules if applicable (send proof of <u>current</u> business income in addition to tax returns)
    - If you do not file taxes, provide an explanation of why: _____

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. Please provide proof for every identified source of income.</u>

If you have no proof of income or no income, please attach an additional page with an explanation.

ASSET INFORMATION (REQUIRED)

This information may be used if your income is above 100% of the Federal Poverty Guidelines.

Do you have any of the following accounts? If "yes", list current balances.

Checking	No ☐ Yes ☐$_____.	Savings	No ☐ Yes ☐$_____.
Health Savings	No ☐ Yes ☐$_____.	Flexible Spending	No ☐ Yes ☐$_____.
Trust	No ☐ Yes ☐$_____.	Health Reimbursement	No ☐ Yes ☐$_____.
Stock/Bond	No ☐ Yes ☐$_____.	Property Equity (excluding primary residence)	No ☐ Yes ☐$_____.
Other	_____.		

PATIENT AGREEMENT

I understand that St. Charles may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

By signing you are attesting that all individuals included in this application are aware you provided their name and information; and they understand that St. Charles may verify information by reviewing credit information and obtaining information from other sources to assist in determining 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 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 Applicant Date