LOWER UMPQUA
HOSPITAL DISTRICT

Lower Umpqua Hospital is a non-profit facility, committed to providing quality medical care to people residing within our local hospital district, regardless of ability to pay. ***Financial assistance is secondary to all other financial resources available, including insurance, government programs, third-party liability and assets. You may be asked to show proof of denial from such programs before your application can be approved***. Assistance is granted for non-elective medically necessary procedures only.

**Please fill out the enclosed Financial Assistance application completely.** Once completed, please contact our Business Office to set up an appointment to discuss the application. Appointments may be made between 9:00 am and 4:00 pm, Monday through Thursday. Please bring the required financial documentation to this appointment. If you need assistance in filling out the form, please indicate this when you call to make an appointment.

We will need the following documentation along with the application in order to complete the process:

1. **A copy of the most recent tax returns filed. If taxes are not filed, please attach a note stating that you do not file taxes and for what reason.**

2. **Proof of Oregon residency in the form of a copy of your Oregon driver's license or a utility bill showing your address.**

3. **Proof of income such as the following documents:**
   - **Proof of Social Security or Retirement income**
   - **Last 3 months pay stubs**
   - **Unemployment or workers' compensation award letters**
   - **AFS award letter or disability award letter or any payment vouchers you receive**
   - **If self-employed, Schedule C and/or profit and loss statement**
   - **If Patient (household) does not have Income: Letter of (financial) support.**

4. **All Patients must provide copies of the most recent statements for the following (if applicable):**
   - **Checking and/or Savings Accounts**
   - **Health Savings Accounts (HSA), Medical Savings Accounts (MSA), Flexible Spending Arrangements (FSA), or Health Reimbursement Arrangements (HRA)**

Once the application has been processed, you will be notified by mail whether you have qualified for a discount of your medical bills and the amount of the discount. If you qualify, your bill will be reduced and you can then contact us to make payment arrangements on the balance of the account.

If you have any further questions, or need further assistance, please contact our business office at **541-271-2171 EXT 3005**

**Tammy Bishop**
Patient Accounts
tbishop@luhonline.com
Lower Umpqua Hospital District

LOWER UMPQUA HOSPITAL DISTRICT

# 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** *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.**
- **Within 14 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<br>□ Other (may specify _____) | Birth Date | | Patient Social Security Number (optional*)<br>**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*)<br>**optional, but needed for more generous assistance above state law requirements* |
| Mailing Address<br>_____<br>City State Zip Code<br>_____ | | | Main contact number(s)<br>( ) _____ (<br>) _____ Email<br>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* _____)

LOWER UMPQUA
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# Charity Care/Financial Assistance Application Form – confidential

## 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. 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:**

- A "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.

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

## EXPENSE INFORMATION

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

Monthly Household Expenses:

Rent/mortgage $_____

Insurance Premiums $_____

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

Medical expenses $_____

Utilities $_____

## ASSET INFORMATION

*This information may be used if your income is above 301% of the Federal Poverty Guidelines.*

Current checking account balance
$_____

Current savings account balance
$_____

Does your family have these other assets?
**Please check all that apply**

□ 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.

## PATIENT AGREEMENT

I understand that Lower Umpqua Hospital District 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