LOWER UMPQUA HOSPITAL DISTRICT (LUHD)
Financial Assistance (Charity Care) Application

Confidential *— Please complete the entire form. If a field does not apply, write 'N/A'.*

SCREENING INFORMATION

Do you need an interpreter? ☐ No ☐ Yes – preferred language _____

Does the patient receive state public services (TANF, SNAP/Basic Food, WIC)? ☐ No ☐ Yes

Is the patient currently experiencing homelessness? ☐ No ☐ Yes

Is the medical care need related to an auto accident or work injury? ☐ No ☐ Yes

APPLICATION INFORMATION

Review & Data Limits: We will review your application promptly. We will only request data necessary to verify household income and third-party liability as allowed by Oregon law.

Timeline: Within 21 calendar days after we receive your completed application, we will notify you by mail or email regarding your qualification status.

Retroactive Refund Right: Oregon law protects you. Patients have up to 12 months after receiving or paying for care to apply. If you qualify retrospectively, any amount you paid will be fully refunded with interest.

PATIENT / APPLICANT INFORMATION

_____ _____ _____
Patient First Name | Middle Name | Last Name

Gender ☐ Male ☐ Female
Other _____ _____ _____
Date of Birth | SSN (optional)

Person Responsible for paying bill _____ _____
Date of Birth

_____ _____
Mailing address | Email address

_____ _____ _____
City | State | Zip code

Employment status of Responsible Party: ☐ Employed – Hire date _____/_____
☐ Self-employed ☐ Unemployed – Duration _____
☐ Student ☐ Disabled ☐ Retired Other _____

See other side ➔

HOUSEHOLD INFORMATION

'Household' means a single individual, or spouses, domestic partners, or a parent and child under 18 living together; and other individuals for whom the applicant is financially responsible.

Name	Date of Birth	Relationship	Employer / Income Source	Gross Monthly Income
1. (Patient)		Self		$
2.				$
3.				$
4.				$

INCOME INFORMATION & VERIFICATION

All family members 18 years or older must disclose overall income. If you cannot provide official documentation, you may submit a written, signed statement describing your current income or financial situation.

Acceptable proof of income includes: A recent W-2 statement; or your most recent tax return; or current pay stubs verifying overall monthly household income; or approval/eligibility letters for unemployment compensation, Social Security, or disability benefits.

Note: *LUHD will never require you to apply for or show proof of denial from Medicaid or any other government program before processing or approving your financial assistance status.*

EXPENSE & ASSET INFORMATION (STRICTLY OPTIONAL)

Note: *This section is completely optional under Oregon Law (HB 3320). It is used only to evaluate eligibility for supplementary assistance programs. You do not need to fill this out to qualify for LUHD financial assistance (Charity Care).*

Monthly Rent/Mortgage $ _____ Checking Balance $ _____

Monthly Utilities $ _____ Savings Balance $ _____

Other assets (stocks/bonds) ☐ No ☐ Yes Owns real estate (non-primary) ☐ No ☐ Yes

PATIENT AGREEMENT & SIGNATURE

I affirm the above information is true and correct to the best of my knowledge. I understand that if the financial information I provide is intentionally false, it may result in a denial of financial assistance, and I may be held responsible for the services provided.

Note: *In compliance with 2026 Oregon regulations, credit bureau checks are not performed as a condition of charity care eligibility.*

_____ _____

Patient / Applicant Signature **Date**