Samaritan Health Services **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.

PLEASE MAIL COMPLETED APPLICATION TO SAMARITAN HEALTH SERVICES, REGIONAL BUSINESS OFFICE, PO BOX 1189, CORVALLIS, OR 97339

OR EMAIL APPLICATION TO shsfinancialassistance@samhealth.org

SCREENING INFORMATION

Does the person completing this form need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*

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.

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

Mailing Address ____ City State Zip Code	Main contact number ( ) ________________________ Authorization to leave a detailed voicemail regarding your financial application: ☐YES ☐NO

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. Please note that only children under the age of 18 years old and claimed on your taxes are considered.

FAMILY SIZE ____________ *Attach additional page if needed*

Name (First and Last)	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):	Claimed on taxes?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed, and proof included with completed application. Sources of income include, for example:

□ Wages (last three months) □ Unemployment □ Self-employment □ Worker's compensation □ Disability □ SSI □ Child/spousal support

□ Work study programs (students) □ Pension □ Retirement account distributions □ Tax Return □ Other (*please explain______________)*

Please check the box for each source of income received along with Tax Returns that will be included with your completed application.

ASSET INFORMATION

This information may be used when reviewing Financial Assistance Application.

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) □ Own a business □ Property (excluding primary residence)

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 Samaritan Health Services 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 Responsible for the bill Date

If you have questions or need other assistance completing the application you can email shsfinancialassistance@samhealth.org or call toll free at (800) 640-5339 or (541) 768-4392. To view the Samaritan Health Services Financial Assistance Policy and for additional information please visit www.samhealth.org/financialassistance