



In keeping with our mission and core values, Samaritan Health Services is committed to providing health care for people regardless of their ability to pay.

What is financial assistance?

Samaritan Health Services provides necessary health care at no charge or a reduced charge to those who meet certain established criteria. If you qualify for financial assistance, some or all of your fees may be lowered. For more information regarding Financial Assistance please visit www.samhealth.org/financialassistance.

Who is eligible for financial assistance?

Financial assistance is generally for people who qualify based on Federal Poverty Guidelines or catastrophic need.

How do I apply?

To be considered for assistance, complete and return this form to Samaritan Health Services within 10 days from receipt of the first billing statement. Completion of this form may enable you to receive free or reduced cost care.

To be considered for financial assistance, you must supply the necessary documentation based on eligibility requirements.

All information relating to the application will remain confidential. Additional information may be required.

What if I need help with the financial assistance application or process?

For answers to your questions or other assistance You can email shsfinancialassistance@samhealth.org or you can call (800) 640-5339 or (541) 768-4392.

What happens if I am eligible?

You will receive a written notice that will include the level of discount authorized. You will be required to set up payment arrangements for your remaining balance. If payments on your remaining balance are not paid, we reserve the right to cancel the discount and assign unpaid balances to our collection agency. Our payment policy is to receive payment in full within a three-month period. Samaritan Health Services' decision for financial assistance does not affect your financial obligation to other health care providers not affiliated with Samaritan Health Services.

What if I'm not eligible?

You will receive a letter informing you of the outcome. Payment arrangements are available in accordance with our policy. If you have any questions, please call our customer service representatives at (800) 640-5339 or (541) 768-4392.

SUBMIT FORM TO:

**SAMARITAN HEALTH SERVICES
REGIONAL BUSINESS OFFICE PO
BOX 1189
CORVALLIS, OR 97339-1189**

or

email the application to:

shsfinancialassistance@samhealth.org

Financial Assistance

In order to complete your Financial Application, you must submit the following for each person related by marriage, domestic partnership, birth or adoption. Dependents 18 years of age and older must complete their own application.

For each person...

Please Include the following:

<p>Are you or the person you are applying with employed?</p>	<ul style="list-style-type: none"> • 3 months proof of gross income (Pay Stubs) and • 3 months of bank statements for all accounts; Business and Personal; and • Most recent complete Federal Tax Return including all schedules
<p>Are you or the person you are applying with unemployed?</p>	<ul style="list-style-type: none"> • Current unemployment benefit letter or proof of all unemployment payments and • Statement from anyone helping you meet your living needs if applicable and • 3 months of bank statements for all accounts; Business and Personal and • Most recent complete Federal Tax Return including all schedules
<p>Are you or the person you are applying with a student?</p>	<ul style="list-style-type: none"> • Current Financial Aid Award letter and • Statement from anyone helping you meet your living needs if applicable and • 3 months of bank statements for all accounts; Business and Personal and • Most recent complete Federal Tax Return including all schedules for yourself and anyone who claims you as a dependent
<p>Are you or the person you are applying with receiving Social Security?</p>	<ul style="list-style-type: none"> • Current copy of Social Security or Disability benefit letter; unless bank statements show the benefit direct deposited • 3 months of bank statements for all accounts; Business and Personal and • Most recent complete Federal Tax Return including all schedules if you still file. If you are no longer required to file, please note that on your application.
<p>Are you or the person you are applying with receiving government assistance?</p>	<ul style="list-style-type: none"> • Current SNAP/Food Stamp benefit approval letter • Current WIC approval letter • Current LIHEAP (Low Income Heating Energy Assistance Program) approval letter • Current National Lunch Program approval letter • Current proof of HUD (Housing and Urban development) approval letter

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.

SCREENING INFORMATION

Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, list preferred language:</i>
Has the patient applied for Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Will be required to apply before being considered for financial assistance</i>
Does the patient receive state public services such as TANF, Basic Food, or WIC? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient currently homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient's medical care need related to a car accident or work injury? <input type="checkbox"/> Yes <input type="checkbox"/> 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 30 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
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (may specify _____)	Birth Date	Patient Social Security Number (optional)
Person Responsible for Paying Bill	Relationship to Patient	Birth Date
Mailing Address		Social Security Number (optional)
_____		Main contact number () _____
_____		Authorization to leave a detailed voicemail regarding your financial application: YES NO (Please circle one)
City	State	Zip Code
Employment status of person responsible for paying bill		
<input type="checkbox"/> Employed (date of hire: _____) <input type="checkbox"/> Unemployed (how long unemployed: _____) <input type="checkbox"/> Self-Employed <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> 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. 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 _____)

Samaritan Health Services

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:

- Current pay stubs 3 months;
- Bank statements for all business and personal accounts 3 months;
- Last year’s income tax return, including schedules if applicable;
- Written, signed statements from employers or others;
- Approval/denial of eligibility for Medicaid;
- Approval of SNAP, HUD, WIC, LIHEAP or National School Lunch program;
- Approval/denial of eligibility for unemployment compensation;
- For patients with a Health Share plan provide proof of billing.

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	\$ _____	Medical Expenses	\$ _____
Insurance Premiums	\$ _____	Utilities	\$ _____
Other Debt/Expenses	\$ _____ (child support, loans, medications, other)		

INSURANCE/HEALTH SHARE INFORMATION

If you currently have health insurance or a health share plan, please list below:

1. _____
2. _____
3. _____

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