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## St. Anthony Hospital

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Dear Patient;

The mission of St Anthony Hospital and Catholic Health Initiatives is to nurture the healing ministry of the Church by bringing it new life, and viability in the 21st century. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we move toward the creation of healthier communities.

In light of this mission, St Anthony Hospital offers a variety of opportunities to assist with medical treatment, whether it be absorbing part of the cost based on need, or helping to identify community or governmental programs to fit your needs.

If you wish to apply for financial assistance on your account, please complete the attached financial form, including the required documentation, and return to St Anthony Hospital within 14 days. Your situation will be evaluated based on Federal criteria and the policy of St Anthony Hospital. If you have any questions or require assistance in the completion of the financial form please contact Patient Accounts at the hospital or call 541-278-3231 or 541-966-0546.

To complete the financial form you will need:

- **Proof of all income - copies of current pay stubs for past 3 months for all household members**
- **W-2 Statements for last year filed for all household members**
- **Copy of most recent Federal Tax Form 1040 (including Schedule C for self employed persons)**
- **Copies of outstanding medical bills**
- **Documentation from AFS or Disability Services showing current benefits if you are receiving assistance**
- **Bank statement for past three months**
- **Completed Financial Application, signed, dated, and a witness signature to attest the validity of the information provided.**
- **Both patient and spouse if applicable must sign this form.**
- **Please refer to the instructions attached for completing the application. All fields on the application must be completed.**

Please answer the following questions:

Have you applied for the Oregon Health Plan and if so when?

What was the determination?

If denied please attach a copy of the denial letter.

**Please Note: If the application is incomplete, it will be returned. We will not be responsible for follow-up on incomplete applications.**

Sincerely,

Patient Accounting Staff

# St. Anthony Hospital

## Financial Assistance Application

_____	/ /	/ /	_____
Patient Name	Social Security#	Date of Birth	Account #
_____	/ /	/ /	_____
Guarantor's Name	Social Security#	Date of Birth	Relationship to Patient
_____		( )	_____
Guarantor Address	City, State, Zip	Home Phone	Length of Residence
_____	_____	_____	_____
Previous Address (If less than 2 years at above)	City, State, Zip	Marital Status	# of Dependents in Household
_____	_____	_____	_____

List Names and Ages of Dependents in Household:

Employer (Guarantor/Patient)	Previous Employer (Guarantor/Patient)	Spouse Employer
Address	Address	Address
Job Title/Length of Employment	Job Title/Length of Employment	Job Title/Length of Employment
Business Telephone #	Business Telephone #	Business Telephone #
Hourly Rate	Hourly Rate	Hourly Rate
Monthly Income Gross	Monthly Income Gross	Monthly Income Gross Address
Monthly Income Net	Monthly Income Net	Monthly Income Net
Other Income Source/Amount	Total Family Monthly Income	Total Family Income last 12 months

Have you applied for Medicaid or any other State/County Assistance? (check one) Yes No (If denied, please attach a copy of the denial letter)

Application Date \_\_\_\_\_ Caseworker Name/Telephone Number \_\_\_\_\_

Have you filed Bankruptcy? Yes No Chapter 7 Chapter 13 Date Filed \_\_\_\_\_ Date of Discharge \_\_\_\_\_

Are you a Homeowner? Yes No Approximate \$ Value \_\_\_\_\_ Approximate Balance on Loan \_\_\_\_\_ Yrs. left on Loan \_\_\_\_\_

Bank Name	Checking Account #	Avg. Checking Balance	Savings Account #	Avg. Savings Balance
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Automobiles(s)

1. Make: _____	Model: _____	Year: _____	Payment Amount _____	Balance Due: _____
2. Make: _____	Model: _____	Year: _____	Payment Amount _____	Balance Due: _____

Other Assets (Stocks, Bonds, Property, Boat, Business, etc.)

Description	Monthly Payment	Payment To	Account #	Balance Due	Limit
Rent/Mortgage	\$			\$	\$
Charge Cards	\$			\$	\$
	\$			\$	\$
	\$			\$	\$
Bank Loans	\$			\$	\$
	\$			\$	\$
School Loans	\$			\$	\$

List Other Expenses Below

	Monthly Payment		Monthly Payment		Monthly Payment
<b>FOOD</b>	\$	<b>MEDICATION</b>	\$	<b>AUTO INSURANCE</b>	\$
<b>UTILITIES</b>	\$	<b>LIFE INSURANCE</b>	\$	<b>OTHER</b>	\$
<b>GAS(CAR)</b>	\$	<b>MEDICAL BILLS</b>	\$	<b>OTHER</b>	\$

TOTAL \$ \_\_\_\_\_ TOTAL \$ \_\_\_\_\_ TOTAL \$ \_\_\_\_\_

TOTAL MONTHLY EXPENSE \$ \_\_\_\_\_

**Note:** Attach additional sheet if necessary. **Important:** income verification must be attached - W2, Pay Stub, Tax Return, etc.

**CERTIFICATION**

1. I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.
2. I will apply for any and all assistance that may be available to help pay this bill.
3. I understand the information submitted is subject to verification; therefore, I grant permission and authorize any bank, insurance co., real estate co., financial institution and credit grantors of any kind to disclose to any authorized agent of St. Anthony Hospital, information as to my past and present accounts, policies, experiences and all pertinent information related thereto. I authorize St. Anthony Hospital to perform a credit check for both guarantor/patient and spouse.

Signature (Guarantor/Patient) \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

Signature (Spouse) \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

## DIRECTIONS FOR COMPLETING FINANCIAL ASSISTANCE APPLICATION

- 1: Complete the patient name, patient's social security number, patient's date of birth, and the hospital account number(s) if known.
- 2: Complete the guarantor name, relationship to patient, guarantor's date of birth, and guarantor's social security number. If the guarantor is the same as the patient, note "Same" in this field.
- 3: Complete the guarantor's address, home telephone number and length of residence at this address.
- 4: Complete the guarantor's previous address (if current residence is less than two years), guarantor's marital status, and number of dependents living in household. If there are no dependents, please mark "-0-" in the dependent field.
- 5: List the names and ages of dependents.
- 6: Complete the employer information for the guarantor or patient, depending upon who has responsibility for the balance. Please complete the name of the employer, the employer's address, the guarantor/patient's job title and length of employment. Please also include the guarantor/patient's business telephone number, hourly (or salary) rate, and the monthly income (both gross and net). If there is no employment, please note how expenses are being met.
- 7: Complete the previous employer information for the guarantor/patient. This includes the employer's name and address, the guarantor/patient's job title and length of employment, business telephone number, hourly rate, and monthly income (both gross and net). If there is no prior employment, mark "N/A".
- 8: Complete the income information for the guarantor/patient's spouse. Include the name of the employer, the employer's address, job title/length of employment, business telephone number, hourly rate, and monthly income (both gross and net). If the spouse is unemployed, or there is no spouse, mark "N/A".
- 9: Complete the other income source/amount. This is for child support, social security, bonus amounts from employers, etc. This also includes rental income, alimony, pension income, welfare and VA benefits. Complete the total family income (add the guarantor/patient net income), then complete the total family income from the last 12 months. If there has been no income, please note how expenses are being met.
- 10: Complete the questions regarding Medicaid and other State/County assistance. Please advise if you have applied for assistance (and on what date). Please provide the assigned Caseworker's name and telephone number. You may attach a separate sheet if needed. Please mark N/A if this field does not apply to you.
- 11: Please indicate if you have ever filed bankruptcy. If you have not filed bankruptcy, please mark "No". Please verify that all questions have been completed. Attach additional paper if needed for any explanations.
- 12: Please complete the homeowner information. If you are a homeowner, please note the approximate dollar value, the approximate balance on the loan, and the number of years left on the loan. If you are not a homeowner, please mark "No".
- 13: Please complete the banking information as requested and list the bank name. Complete the checking account number and provide the average checking account balance. Please do the same for the savings account field. If there is no savings account, please place "N/A" in the savings field.
- 14: For automobile information, please list the make, model and year of your vehicle. Please list the monthly payment amount and the current balance.
- 15: Please complete the section listing other assets you may have. This includes stocks, bonds, property, boats and businesses you may own. Use additional paper if needed to give complete details. If there are no additional assets, please mark "N/A".

### HOW TO COMPLETE THE MONTHLY EXPENSE SECTION:

**RENT/MORTGAGE:** Please verify the amount you are paying in rent or by mortgage. Indicate to whom the payment is made, the account number and the current balance due. If you do not pay rent or mortgage, please note why you have no payment or if you live with relatives or others. Use additional paper if needed.

**CHARGE CARDS:** Please indicate any charge card payments you are currently making. Please indicate the monthly pay-

ment amount, to whom the payment is made, the account number and the current balance due. Please indicate the credit limit for each card. Use additional paper if you needed to complete this field. If you have no charge cards please note "N/A".

**BANK LOANS:** Please indicate any bank loans you may be paying. Indicate the monthly payment amount, to whom the payment is made, the account number and the current balance due. Use additional paper if needed to completely explain this field. If you have no bank loans, please mark "N/A".

**SCHOOL LOANS:** Please list any educational loans you may be paying. This can include, but not be limited to, college loans, private school loans (or tuition), day-care expenses or any other loans that apply to education. Please use additional paper if needed. Please specify if you are paying school loans, etc. If this does not apply to you, please mark "N/A".

**LIST OTHER MONTHLY EXPENSES:**

**FOOD:** Please list the amount paid for food on a monthly basis.

**UTILITIES:** Please list the amount paid on a monthly basis for electricity, gas, water, trash and any other utility you may pay. Please add these and place the total (for all of them) in the utilities section. If there are no monthly utilities paid, please mark "N/A" in this section and explain. Use a separate sheet of paper if needed.

**GAS (CAR):** Please list the amount paid on a monthly basis for transportation needs related to your vehicle. If there is no payment made on a monthly basis for gas, please mark the field "N/A".

**MEDICATION:** Please add the amounts you pay on a monthly basis for medication needs. If there are several prescriptions or medications you take, please add them together and place the total amount in this section. If there are no monthly medication payments, please place "NA" in this section.

**LIFE INSURANCE:** If you have a life insurance policy, please indicate the monthly amount you pay. If there is no payment, please place "N/A" in this section.

**MEDICAL BILLS:** Please add any medical bills you may be paying on a monthly basis. This may include, but not be limited to, physician bills, insurance co-pays, insurance deductibles, other hospital bills, radiology bills, ambulance bills, etc. Please use a separate sheet of paper to list these amounts. Add them together and place the total amount paid on a monthly basis for these accounts in this section. If there are no monthly medical payments being made, please place "N/A" in this section.

**AUTO INSURANCE:** Please place the total amount you pay on a monthly basis for auto insurance. If you pay on a quarterly basis, please divide the quarterly payment by three and place the amount in this section. If you pay every six months, please divide the total amount you pay by six and place the amount in this section. If there is no monthly payment being made, please mark N/A in this section.

**OTHER:** This includes any monthly payments you currently are making that are not listed in the previous sections. Please provide details of what you are paying, to whom, and the balances due. Please use a separate sheet of paper if needed. If this section does not apply to you, mark "N/A".

**TOTAL MONTHLY PAYMENTS:** Please total all the above payments and place this amount in this section.

**PLEASE READ THE FINE PRINT!!!!!!!**

**DOCUMENTATION:** Please notice that your signature indicates you have agreed to attach all income verification. In addition to the items requested by this application, you may attach bank statements, copies of social security checks (or letters). If there is no income, please verify how expenses are being met. It is important to explain a lack of income completely so that full consideration of your application can be made. If the guarantor/patient or the spouse is self-employed, please attach the last 2-3 months of bank statements. All documentation must be attached for full consideration. If the application is incomplete, it will be returned. We will not be responsible for follow-up on incomplete applications.

**WHAT YOU ARE AGREEING TO:**

1. Stating that the guarantor/patient has completed this form accurately.
2. Stating that the guarantor/patient will apply for any assistance to pay this bill.  
This may include acquiring a bank loan or putting the balance on your credit card.
3. Authorizing St. Anthony Hospital to obtain credit information and perform a credit check.