Catholic Health Initiatives
Imagine better health.℠

2801 St Anthony Way
Pendleton, OR 97801

____/____/____
Date

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. St Anthony Hospital provides care without regard to ability to pay.

In light of this mission, St Anthony Hospital offers a variety of opportunities to assist with medical treatment, whether it is absorbing part of the cost based on need or helping to identify community or governmental programs to fit your needs. This program does not cover services provided by any independent contractors – including but not limited to radiologists, hospitalists, anesthesiologists, and emergency room physicians.

If you wish to apply for financial assistance for your account, please complete the attached application and return it to: ***St Anthony Hospital, Attn: Marcy-MECS, 2801 St Anthony Way, Pendleton, OR 97801***. Your situation will be evaluated based on **300% of the Federal Poverty Level income guidelines**. We will gladly consider you for financial assistance provided the application is complete, signed and returned with the required documents listed below within 14 days of the date of this letter. We will make every effort to process your application within 30 days of receipt but you must continue to make payments on the account while this application is being reviewed. ****INCOMPLETE APPLICATIONS CANNOT BE PROCESSED****

REQUIRED DOCUMENTS

● At least **one piece of supporting documentation that verifies household income** may be required. Supporting documentation can include but is not limited to:

- Most recent year's US Individual 1040 tax return (**all forms filed including W-2 and all schedules**). If you need to obtain a copy, please call 1-800-908-9946 for a free transcript.
- Current W-2
- One month of current pay stubs
- Social Security Benefit letter for current year
- Pension benefit letter for current year
- Unemployment benefit letter
- Child support
- Spousal support
- School account summary by term (for college students),
- Year-to-date Profit/Loss statement (if self-employed), etc. Verification must show GROSS income.
- Copies of any outstanding medical bills other than St Anthony Hospital.

Additional information may be requested in order to qualify for assistance

● Patients approved for Financial Assistance will be granted eligibility for a period of six months from the determination date. Financial Assistance will also be applied to all eligible accounts incurred for services received six months prior to determinate date.

In order to help us identify your account(s) you wish to have considered for financial assistance, please mark below if you have received or expect to receive services from any of the following:

☐ HOSPITAL INPATIENT
☐ HOSPITAL OUTPATIENT
☐ COMMUNITY EDUCATION
☐ ST ANTHONY HOME HEALTH OR HOSPICE
☐ SURGERY - date _____
☐ OTHER - _____

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Financial Assistance Application (FAA)

Patient Demographics

Patient Name: Last, First, Middle	**Social Security # (If available)**	**Date of Birth**	**Account #** **Location of Service**
Guarantor Name: Last, First, Middle	**Social Security # (If available)**	**Date of Birth**	**Relationship to Patient**
Patient/ Guarantor Address	**County of Residence**	**Home Phone #**	**Alternate Phone #**
City	**State**	**Zip Code**	**Homeowner? Yes No**
Have you applied for Medicaid or any other State/County Assistance? (Circle one) Yes No **If Yes, Please provide the following:**			
Application Date:		**Status of Application:**	
Caseworker Name:		**Caseworker Phone Number:**	

Household Information

Marital Status:	**Married**	**Single**	**Separated**	**Divorced**	**Widowed**

Dependent Names	**Relationship**	**Date of Birth**

Employment/Household Income and Expenses

Patient/Guarantor Employer Name	**Gross Monthly Income: $**	**Provide verification**
If income is $0, please explain.		**Provide documentation**
Spouse's Employer Name	**Gross Monthly Income: $**	**Provide verification**
If income is $0, please explain.		**Provide documentation**
Other Income Source:	**Gross Monthly Income: $**	**Provide verification**
EXPENSES ARE NOT REQURIED FOR NHSC APPLICATIONS		
Household Monthly Expenses	**Total Monthly Expenses: $**	**N/A**

IMPORTANT: To qualify for assistance**, at least one piece of supporting documentation that verifies household income** may be required. Supporting documentation can include but is not limited to, most recent year's tax return, a current W-2, 1 month of current pay-stubs, signed letter of support, etc.

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PLEASE READ THE FOLLOWING BEFORE SIGNING AND DATING THE APPLICATION

Please be advised that your signature indicates you have agreed to attach income verification.

- I certify that the information I have provided is true and accurate to the best of my knowledge.
- I will independently or with the assistance of hospital personnel apply for ANY and ALL Assistance which may be available through federal, state, local government and private sources to help pay this healthcare bill.
- I understand that if I do not cooperate with my healthcare provider in providing requested information, my application may be denied for possible financial assistance.
- I understand that the information which I submit is subject to verification by my healthcare provider, including credit reporting agencies and subject to review by Federal and/or State agencies and others as required.
- I understand that additional information may be requested in order to qualify for assistance.

Signature (Applicant/Guarantor)	**Date**

NOTE: Guarantor is the "patient, caregiver, or entity" responsible for payment of the health care bill.

Return Completed Application and Documents to:

CHI ST ANTHONY HOSPITAL
Attn: Marcy - MECS
2801 ST ANTHONY WAY
PENDLETON, OR 97801

Phone: (541) 278-3244
Fax: (541) 966-0542