Financial Assistance Application Form Instructions

Legacy Health wants to provide financial assistance to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance. *For more information visit us at www.legacyhealth.org in the search bar type* ***financial assistance.***

What does financial assistance cover? Financial assistance covers medically necessary services provided by Legacy Health depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations. This assistance will cover Legacy Health physician charges as well.

If you have questions or need help completing this application, please contact Customer Service:
Customer Service can be reached at 503-413-4048 (toll free 800-495-7076). You may obtain help for any reason, including disability and language assistance.

In order for your application to be processed, you must:

- □ **Provide us information about your family**
  List the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- □ **Provide us information about your family's gross monthly income (income before taxes and deductions)**
- □ **Provide documentation for family income**
- □ **Attach additional information if needed**
- □ **Sign and date the form**

Note: **You do not have to provide a Social Security number to apply for financial assistance**. If you provide us with your Social Security number it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

Mail or fax completed application with all documentation to: Legacy Health PO Box 4037 Portland, OR 97208.
Fax: 503-413-2753. Be sure to keep a copy for yourself.

To submit your completed application in person: Please stop by any Legacy Health facility. Hospital sites have financial counselors, available by appointment, to assist you.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 10 business days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We are here to help. Please submit your application promptly!
You will continue to receive bills until we receive your information.

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SCREENING INFORMATION

Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*

Has the patient applied for Medicaid? □ **Yes** □ **No**

Is the patient currently homeless? □ **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.
- Within 10 business 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
□ 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(s) ( ) _____ ( ) _____ Email Address: _____

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.

FAMILY SIZE _____ *Attach additional page if needed*

Name	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):	Also applying for financial assistance?
					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_____)*

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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:

- A "W-2" withholding statement; or
- Current pay stubs (*3 months*); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

Healthcare Savings Account Information (HSA)

These funds will need to be applied to owing balances prior to Financial Assistance

Health Savings Account (HSA) Balance $_____

PATIENT AGREEMENT

I understand that Legacy Health may verify information provided and obtain 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 Applying Date